

MARYLAND STATE DEPARTMENT OF HEALTH

FOR STATE
HEALTH DEPT.



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

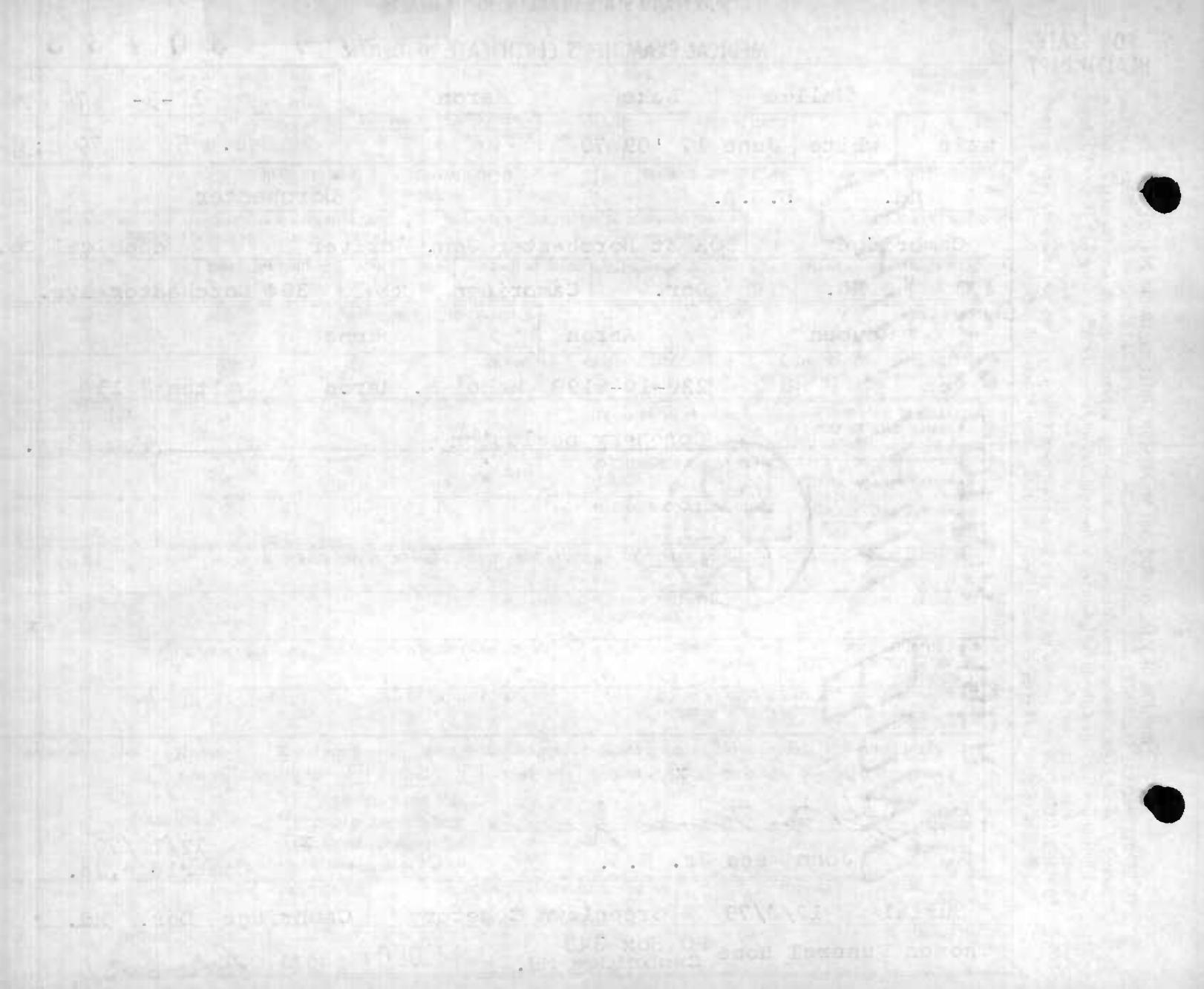
9 30933

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

1. DECEASED NAME (Type or Print)			First Hallie	Middle Lake	Last Aaron	2a. DATE KNOWN OF ESTI- MATED	Month 12-5-	Day 19 79	Year PM	2b. HOUR
3. SEX male	4. RACE white	S. DATE OF BIRTH June 17 '09	6. AGE (in years last birthday) 70 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	2c. DATE PRONOUNCED DEAD Month Dec. Day 5 Year 1979	2d. HOUR 4:35			
7a. BIRTHPLACE (State or foreign country) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Dorchester				
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) DOA at Dorchester Gen. driver			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) chemical Co.			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Dor.		13c. CITY OR TOWN Cambridge	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	13e. STREET AND NUMBER 304 Dorchester Ave.				
14. FATHER'S NAME Reuben		Middle Aaron	Lost	15. MOTHER'S MAIDEN NAME Rena						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes		16b. SOCIAL SECURITY NO. WW 2		17. INFORMANT Mabel M. Aaron		ADDRESS Item # 13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> DUE TO, OR AS A CONSEQUENCE OF 410- (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Few Mins.										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town	County	State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE 		CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county) Cambridge, Md.								
EXAMINER'S NAME (Type) John Mace Jr. M.D.		22b. DATE SIGNED 12/12/79								
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 12/8/79	23c. NAME OF CEMETERY OR CREMATORIAL Greenlawn Cemetery		23d. LOCATION (City or Town) Cambridge Dor. Md.		(County) (State)			
24. FUNERAL DIRECTOR Thomas Funeral Home		ADDRESS PO Box 348 Cambridge Md.		25a. REC'D BY REGISTRAR DEC 14 1979		25b. REGISTRAR'S SIGNATURE 				

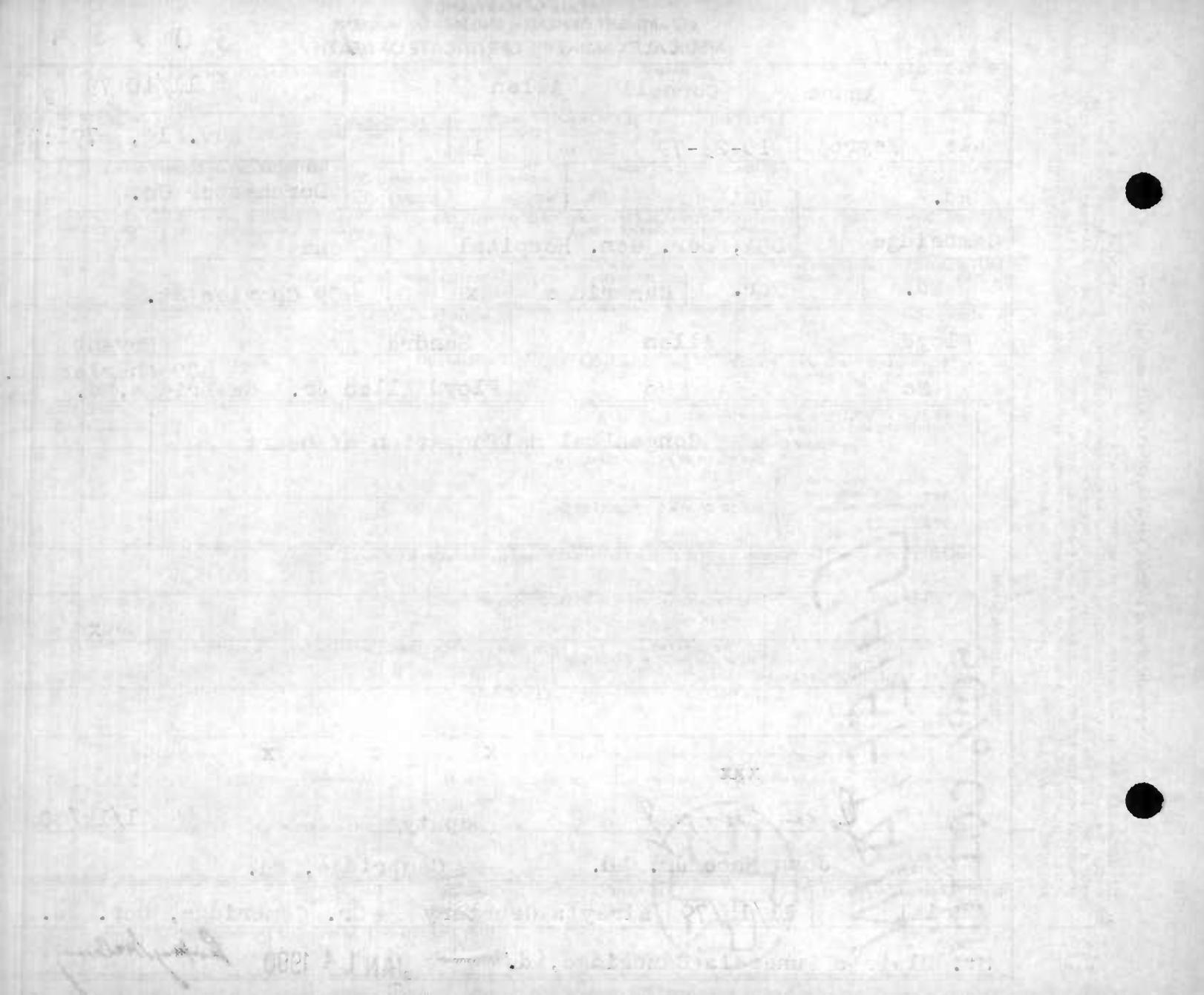


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3, RETAIN PAGE FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 30934					
1 - STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		2a. DATE KNOWN OF ESTI- DEATH MATED		MONTH 11/10	DAY 79	YEAR 19	2b. HOUR P M	
		Andre			Cornell		Allen				<input checked="" type="checkbox"/>	<input type="checkbox"/>					
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD		MONTH Nov. 10,	DAY 19	YEAR 79	2d. HOUR 1:20 P M
Male		Negro		10-23-79		YRS.		18									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester Co.											
Md.		USA															
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DOA, Dor. Gen. Hospital										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Cambridge												None					
13a. STATE Md.		13b. COUNTY Dor.		13c. CITY OR TOWN Cambridge		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 409 Charles St.									
14. FATHER'S NAME First		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME First		Middle		Last							
Floyd				Allen		Sandra				Bryant							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		409 Charles St.							
No				No		Floyd Allen Jr.		Cambridge, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
IMMEDIATE CAUSE (a) Congenital malformation of heart DUE TO, OR AS A CONSEQUENCE OF 7469 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost.																	
(b) _____ DUE TO, OR AS A CONSEQUENCE OF																	
(c) _____																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE							
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .												TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER					
EXAMINER'S NAME (TYPE OR PRINT) John Mace Jr. Md.												DATE SIGNED 1/14/80					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial 11/14/79		23c. NAME OF CEMETERY OR CREMATORIAL Airey's Cemetery		23d. LOCATION CITY OR TOWN Nr. Cambridge, Dor. Md.		COUNTY		STATE Md.							
24. FUNERAL DIRECTOR NAME		ADDRESS St. Clair's Funerals Cambridge, Md.		25a. DATE REC'D. BY REGISTRAR JAN 14 1980		25b. REGISTRAR'S SIGNATURE Lily McEvoy											
BP																	
DHMH - 17 (VR A15 ME (5))																	
15M 7/77																	

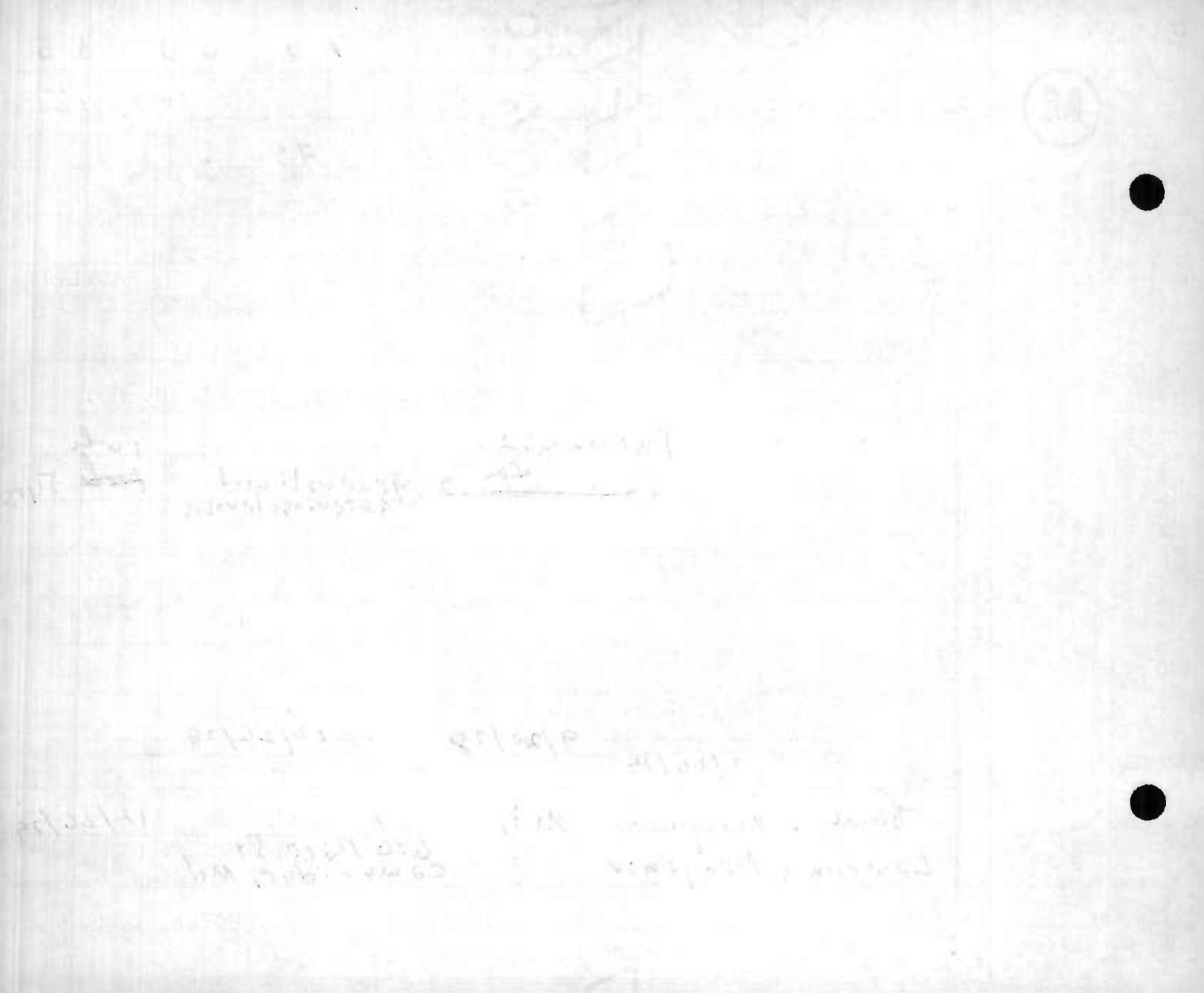


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Please sign the certificate within 24 hours of the death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.		
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR 11:15 AM		
			MARY E BAKER						12 26 79					
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
Female			White			12 26 89			90			YRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.		
DELAWARE			Yes						DORCHESTER					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
CAMBRIDGE, MD			CAMBRIDGE HOUSE NURSING FACILITY			House Wife			FACILITY					
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS		
MARYLAND			DORCHESTER			CAMBRIDGE						CAMBRIDGE HOUSE NURSING		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST											
EDWARD MURRAY			HETTIE MURRAY											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS					
NO			222-22-6282			EDWARD N. EVANS			, CAMBRIDGE, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i> . <i>4409</i> Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause (c). (b) <i>Pneumonia. Generalized Arteriosclerosis</i> (c) <i>Arteriosclerosis</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 week</i> <i>late 54 yrs</i>		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from <i>9/20/79</i> , 19_____, to <i>12/26/79</i> , 19_____, that (I) (we) last saw the deceased alive on <i>12/26/79</i> , 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <i>Lawrence Kucyansky M.D.</i>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>12/26/79</i>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Lawrence Kucyansky</i>			22e. ADDRESS <i>610 Race St Cambridge, Md</i>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE DEC. 29, 1979			23c. NAME OF CEMETERY OR CREMATORIAL ROXANA CEMETERY			23d. LOCATION CITY OR TOWN ROXANA, SUSSEX, DELAWARE			COUNTY STATE		
BURIAL														
24. FUNERAL DIRECTOR NAME <i>Ortug Nelson</i>			FRANKFORD, DELAWARE			25a. DATE REC'D. BY REGISTRAR DEC 31 1979			25b. REGISTRAR'S SIGNATURE <i>Ortug Nelson</i>					

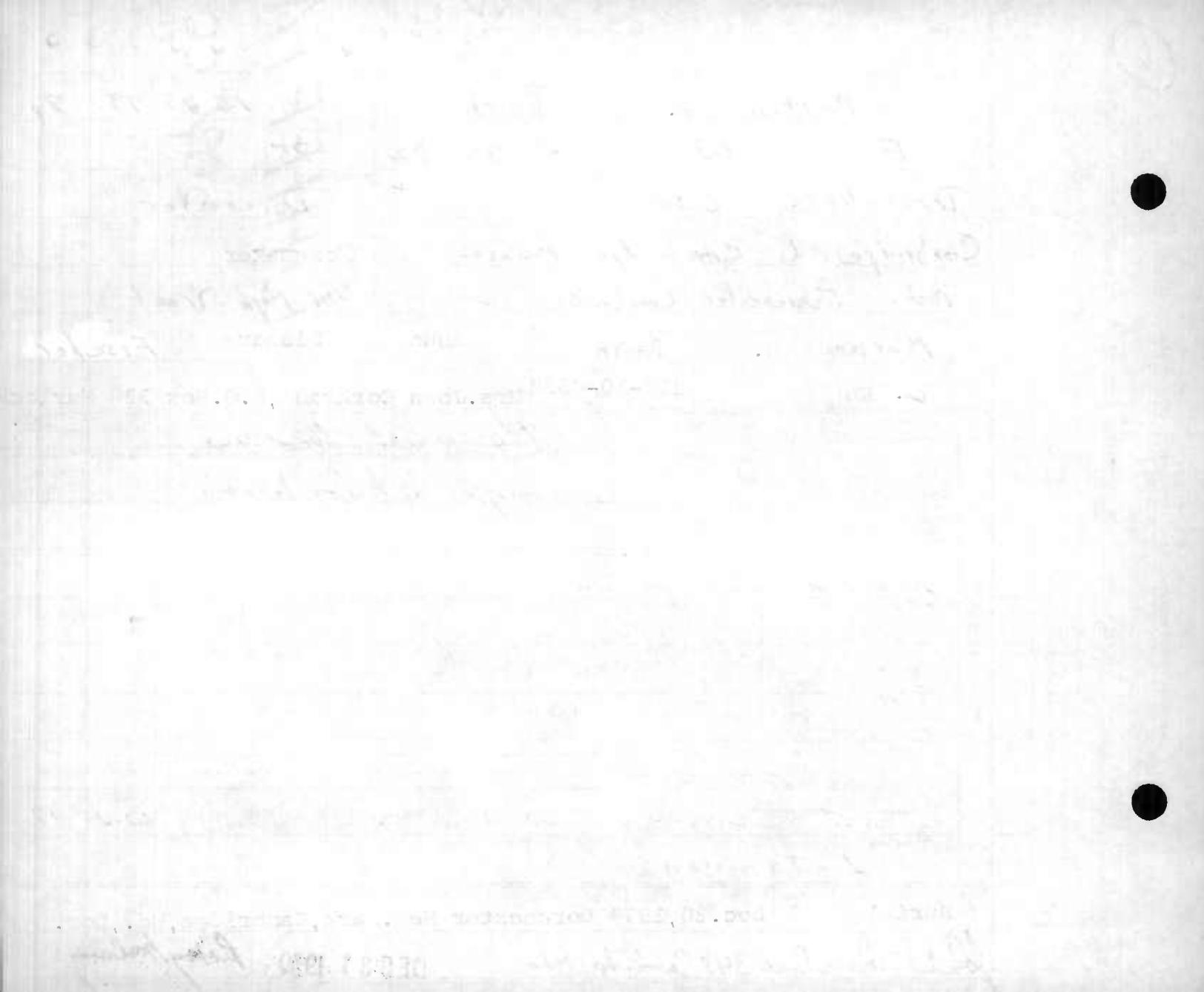


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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified before

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 7930936		
1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR 12 25 79									2b. HOUR 8 PM		
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE Mattie A.			LAST Barth								
3. SEX F			4. RACE W			5. DATE OF BIRTH MONTH 3 DAY 30 YEAR 92			6. AGE (IN YEARS LAST BIRTHDAY) 85			IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN		
7a. BIRTHPLACE STATE OR FOREIGN COUNTRY Dorchester City			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester			MD		
10. CITY OR TOWN OF DEATH Cambridge, Md.			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Cambridge House			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY Deer					
13a. STATE Md.			13b. COUNTY Dorchester			13c. CITY OR TOWN Cambridge			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 411 High Street		
14. FATHER'S NAME FIRST Herman			MIDDLE W.			LAST Barth			15. MOTHER'S MAIDEN NAME Anna Fisher					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, <input type="checkbox"/> NO, <input checked="" type="checkbox"/> OWN)			16b. SOCIAL SECURITY NO. 212-10-4559			17. INFORMANT Mrs. Joan Corkran			ADDRESS P.O. Box 338 Hurlock					
18. CAUSE OF DEATH (Enter only one cause per line for 1a), 1b), and 1c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost. { DUE TO, OR AS A CONSEQUENCE OF (b) Generalized Atherosclerosis DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Md.		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Open Respiratory Infection														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED 12-25-79		
22b. SIGNATURE E. Tanman			22d. PHYSICIAN'S NAME (TYPE OR PRINT) E. Tanman			22e. DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Dec. 28, 1979			23c. NAME OF CEMETERY OR CREMATORIAL Dorchester Mem. Park, Cambridge, Md. Dor.			23d. LOCATION CITY OR TOWN			COUNTY	STATE	
24. FUNERAL DIRECTOR NAME John Thomas Bal 348 Cambridge, Md.			ADDRESS			25a. DATE REC'D. BY REGISTRAR DEC 31 1979			25b. REGISTRAR'S SIGNATURE Harry McElroy					

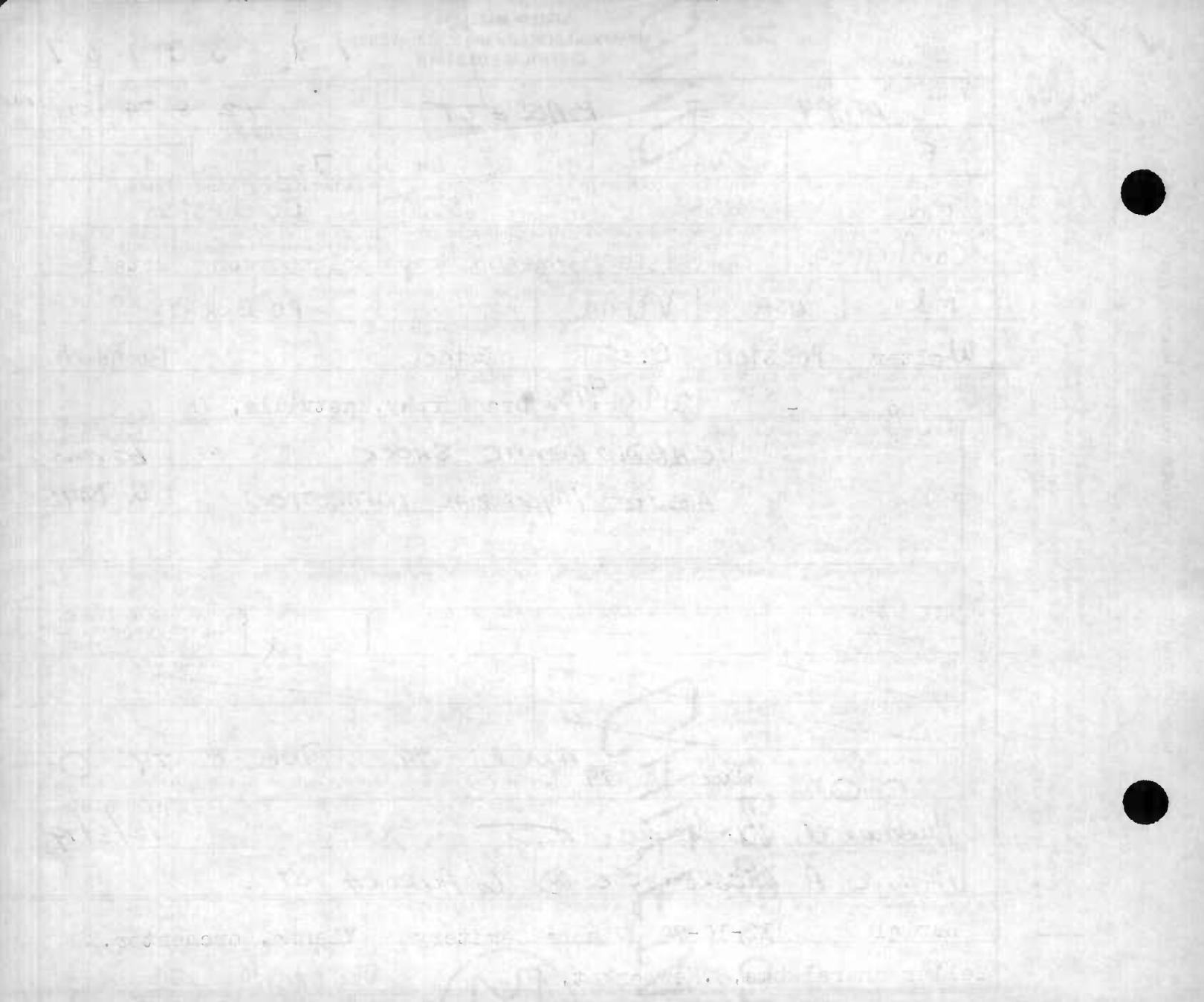


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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.
1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
MARY				E.	BASSETT		12	8	79	12	00	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
F		Caucasian		MONTH	DAY	YEAR	75			IF UNDER 24 HRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
Md		USA					Dorchester					
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
Cambridge				Dorchester General Hosp				Salesperson			Retail	
13a. STATE		13b. COUNTY		13c. CITY, OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS			
Md		USA		Vienna					P.O. Box 245			
14. FATHER'S NAME				FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			LAST		
Walter Preston Bassett							Ethel			Brohawn		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
No				219-01-4732			Ora Murphy, Eastville, VA					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIOGENIC SHOCK</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ACUTE MYOCARDIAL INFARCTION</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
												60 min
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												2 days
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN COUNTY STATE			
22a. I certify that <input type="checkbox"/> (this hospital) attended the deceased from April 1979 to Dec 8 1979, that <input checked="" type="checkbox"/> (I) we lost saw the deceased alive on Dec 8 1979, and that in <input type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (I) we did not view the body after death.												
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED			
Michael A. Moskewicz <input checked="" type="checkbox"/>									12/8/79			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS									
Michael A. Moskewicz <input checked="" type="checkbox"/>			6 Aurora St.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12-10-79			23c. NAME OF CEMETERY OR CREMATORIAL Vienna Cemetery			23d. LOCATION CITY OR TOWN Vienna, Dorchester MD COUNTY STATE			
24. FUNERAL DIRECTOR NAME Zeller Funeral Home, E. New Market, MD			ADDRESS			25a. DATE REC'D. BY REGISTRAR DEC 14 1979			25b. REGISTRAR'S SIGNATURE Lester A. Bassett			

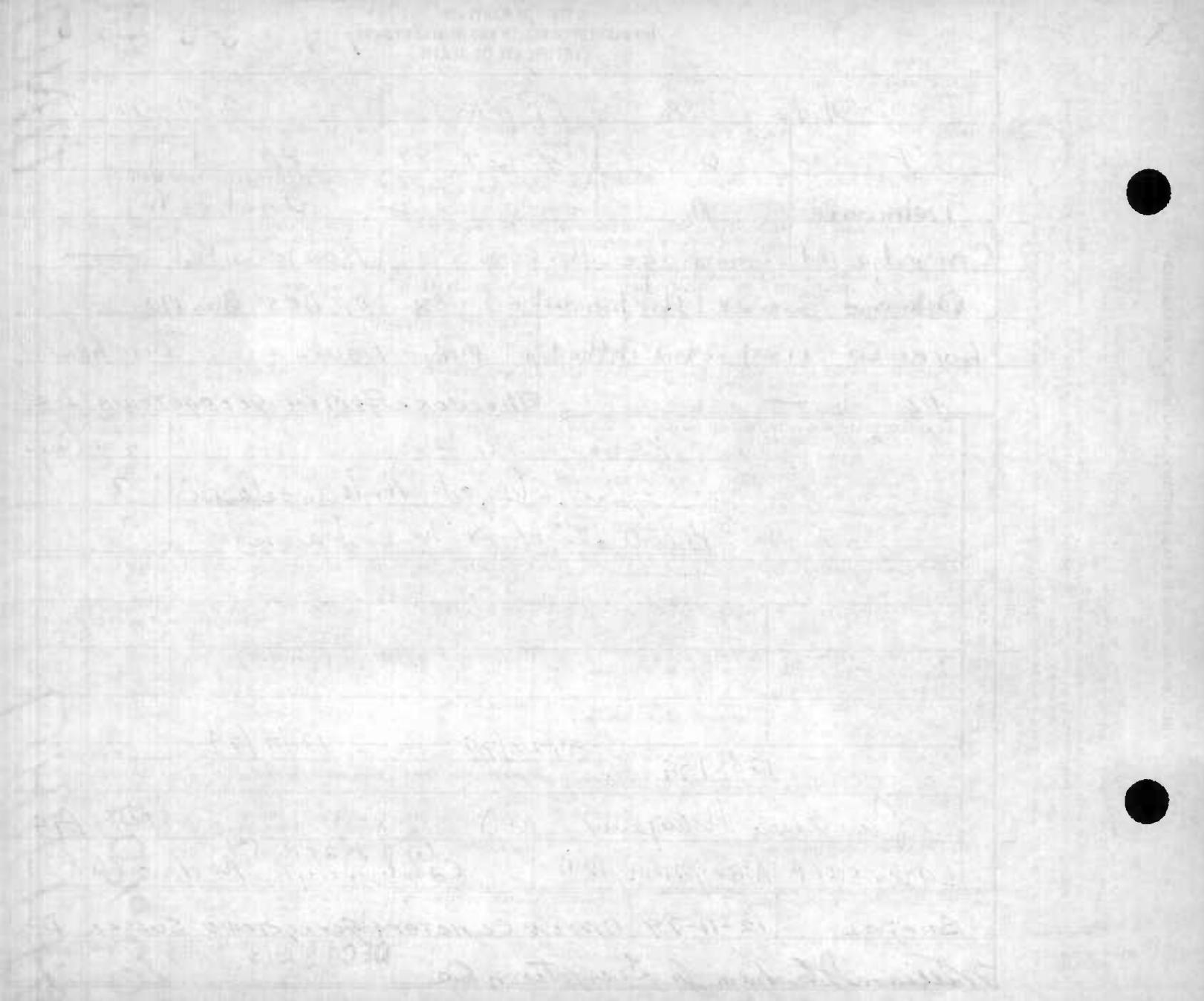


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

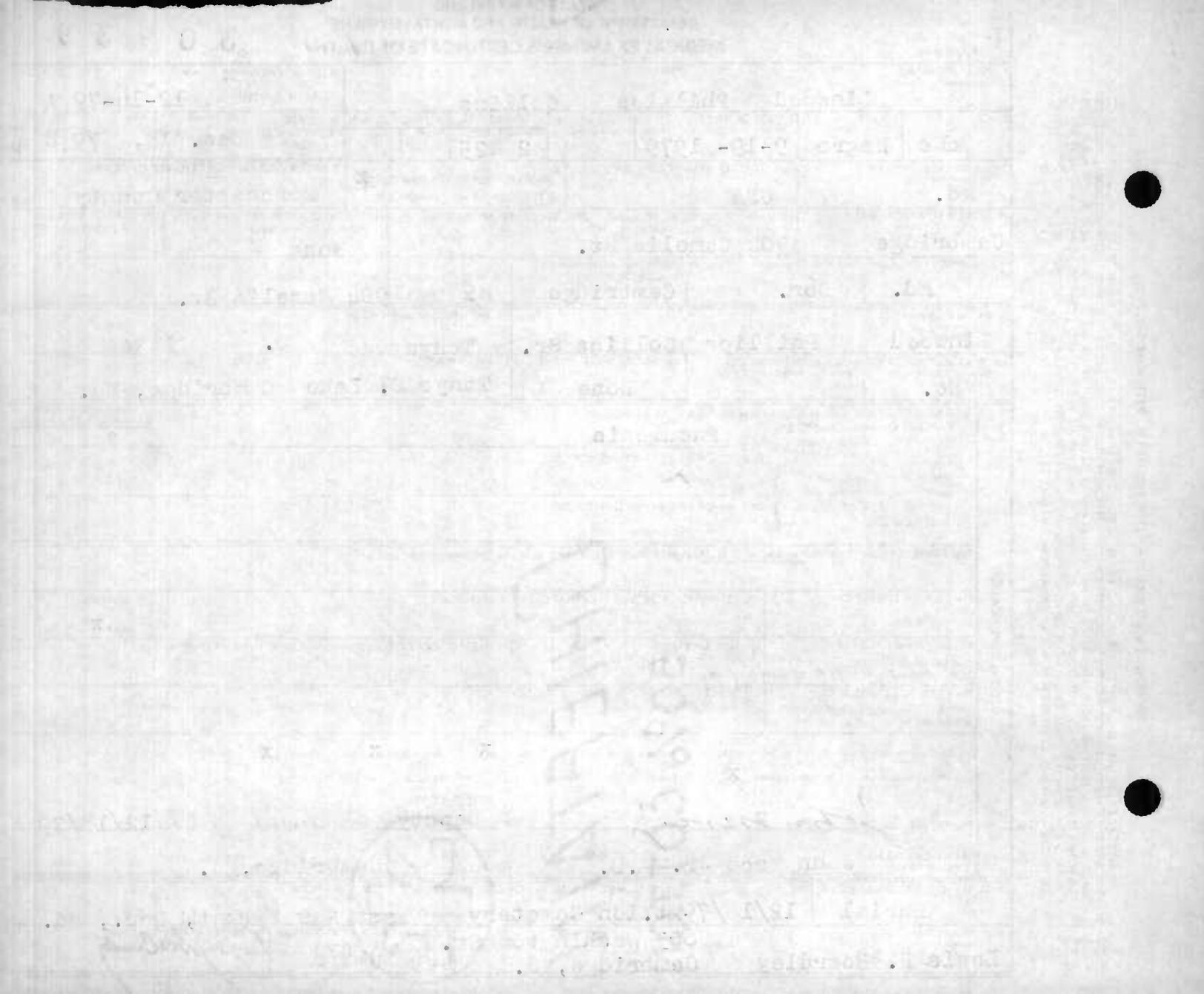
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.	
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
			Dolores B. Berks						12 7 79			7 40 PM	
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR	
F			W			4 27 99			80 YRS.			MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.	
Delaware			A.						Dorchester				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Cambridge, Md			Cambridge House			Housewife							
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS	
Delaware			Sussex			Barberston						RED #5 Box 170	
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS	
Lorenzo Washington Pittington			Mary Lavenia Buchanan			NO						Theodore Burton - Georgetown, D.C.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			4370			Renal Failure						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			(b)			Glucosuria						30 days	
			(c)			Hypertension of right hemiparesis						?	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 9/21/79, 19, to 12/7/79, 19, that (I) (we) lost saw the deceased alive on 12/3/79, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED				
Laurenne Maryann MD												12/7/79	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			610 Race St. Cambridge, Md 21613							
Burial			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN COUNTY STATE				
Burial			12-11-79			Union Cemetery Georgetown Sussex, De							
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
William Graham Jr. Georgetown, D.C.						DEC 12 1979							



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.
 PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES.
 TO FUNERAL DIRECTOR: PAGE 5 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 30939					
1 - STATE REGISTRAR			2a. DATE KNOWN <input type="checkbox"/> MONTH DAY YEAR 12-14-79									2b. HOUR AM					
1. DECEASED NAME (TYPE OR PRINT) Linwood Phillips Collins			MIDDLE			LAST			IF UNDER 1 YR. <input type="checkbox"/> MONTHS 2			IF UNDER 24 HRS. <input type="checkbox"/> DAYS 25			HOURS MIN.		
3. SEX Male Negro			5. DATE OF BIRTH MONTH DAY YEAR 9-19-1979			6. AGE (IN YEARS LAST BIRTHDAY) YRS. 25			2c. DATE PRONOUNCED DEAD Dec. 14, 1979			MONTH DAY YEAR 8 AM			2d. HOUR AM		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester County			MD.					
10. CITY OR TOWN OF DEATH Cambridge			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 904 Camelia St.									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) None			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Md.			13b. COUNTY Dor.			13c. CITY OR TOWN Cambridge			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 904 Camelia St.					
14. FATHER'S NAME FIRST Linwood MIDDLE Phillips LAST Collins Sr.			15. MOTHER'S MAIDEN NAME FIRST Tonya MIDDLE O. LAST Lake														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No.			16b. SOCIAL SECURITY NO. None			17. INFORMANT Tanys Ol Lake			ADDRESS Cambridge, Md.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia 7 486- Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ?					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .												TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER					
ACTUAL SIGNATURE John Mace Jr. M.D.												DATE SIGNED 12/18/79					
EXAMINER'S NAME (TYPE OR PRINT) John Mace Jr. M.D.			ADDRESS Cambridge, Md.														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/18/79			23c. NAME OF CEMETERY OR CREMATORIUM Zion Cemetery			23d. LOCATION CITY OR TOWN East New Market, Dor.			COUNTY STATE					
24. FUNERAL DIRECTOR NAME Lewis H. Boardley			ADDRESS 603 Washington St.			25a. DATE REC'D. BY REGISTRAR DEC 20 1979			25b. REGISTRAR'S SIGNATURE								
BP																	
DHMH - 17 (VR A15 ME (5)) 15M 7/77																	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.				
1. FOR STATE REGISTRAR			2a. DATE OF DEATH			MONTH			DAY		YEAR		2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST													
LILLIAN B CRANE													12 17 79 8:30 P.M.			
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
FEMALE			White			MONTH DAY YEAR			82			MONTHS DAYS		HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
Maryland			U.S.						Dorchester							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Cambridge			CAMBRIDGE HOUSE			Homemaker										
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS				
Md.			Dor.			Cambridge						Glenburn Ave.,				
14. FATHER'S NAME			LAST			15. MOTHER'S MAIDEN NAME										
Herman			W. Barth			Anna Fisher Deer										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
NO			220-44-0735			Mrs. Joan Corkran, Hurlock, Md.,										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a)																
410- Myocardial infarction																
DUE TO, OR AS A CONSEQUENCE OF (b),																
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																
DUE TO, OR AS A CONSEQUENCE OF (c),																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) ASCD, Organic Brain Syndrome																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on 12-17-1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED							
E. Toman			MD													
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS													
E. Toman			17 Frauline St. Cambridge, Md.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN			COUNTY		STATE		
Burial			Dec. 20, 1979			Dorchester Mem. Park, Cambridge, Dor., Md.										
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE							
Thomas Funeral Home, Cambridge, Md.,						DEC 20 1979						Ricky McCreedy				

1. *Leucosia* sp. (Diptera: Syrphidae) was collected from the surface of the soil at the base of a tree in a dry, open woodland area. The tree was a small, leafless tree with a trunk diameter of approximately 10 cm. The soil was light-colored and sandy. The plant material was a mix of dried leaves and twigs.

2. *Leucosia* sp. (Diptera: Syrphidae) was collected from the surface of the soil at the base of a tree in a dry, open woodland area. The tree was a small, leafless tree with a trunk diameter of approximately 10 cm. The soil was light-colored and sandy. The plant material was a mix of dried leaves and twigs.

3. *Leucosia* sp. (Diptera: Syrphidae) was collected from the surface of the soil at the base of a tree in a dry, open woodland area. The tree was a small, leafless tree with a trunk diameter of approximately 10 cm. The soil was light-colored and sandy. The plant material was a mix of dried leaves and twigs.

4. *Leucosia* sp. (Diptera: Syrphidae) was collected from the surface of the soil at the base of a tree in a dry, open woodland area. The tree was a small, leafless tree with a trunk diameter of approximately 10 cm. The soil was light-colored and sandy. The plant material was a mix of dried leaves and twigs.

5. *Leucosia* sp. (Diptera: Syrphidae) was collected from the surface of the soil at the base of a tree in a dry, open woodland area. The tree was a small, leafless tree with a trunk diameter of approximately 10 cm. The soil was light-colored and sandy. The plant material was a mix of dried leaves and twigs.

6. *Leucosia* sp. (Diptera: Syrphidae) was collected from the surface of the soil at the base of a tree in a dry, open woodland area. The tree was a small, leafless tree with a trunk diameter of approximately 10 cm. The soil was light-colored and sandy. The plant material was a mix of dried leaves and twigs.

7. *Leucosia* sp. (Diptera: Syrphidae) was collected from the surface of the soil at the base of a tree in a dry, open woodland area. The tree was a small, leafless tree with a trunk diameter of approximately 10 cm. The soil was light-colored and sandy. The plant material was a mix of dried leaves and twigs.

8. *Leucosia* sp. (Diptera: Syrphidae) was collected from the surface of the soil at the base of a tree in a dry, open woodland area. The tree was a small, leafless tree with a trunk diameter of approximately 10 cm. The soil was light-colored and sandy. The plant material was a mix of dried leaves and twigs.

9. *Leucosia* sp. (Diptera: Syrphidae) was collected from the surface of the soil at the base of a tree in a dry, open woodland area. The tree was a small, leafless tree with a trunk diameter of approximately 10 cm. The soil was light-colored and sandy. The plant material was a mix of dried leaves and twigs.

10. *Leucosia* sp. (Diptera: Syrphidae) was collected from the surface of the soil at the base of a tree in a dry, open woodland area. The tree was a small, leafless tree with a trunk diameter of approximately 10 cm. The soil was light-colored and sandy. The plant material was a mix of dried leaves and twigs.



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9 30941

1. DECEASED-NAME (Type or Print)			First William	Middle L.	Last Cranfield	2a. DATE KNOWN <input checked="" type="checkbox"/> OF ESTI- DEATH MATED <input type="checkbox"/> Dec. 29, 1979	Month Dec.	Day 29	Year 1979	2b. HOUR 5:00 M	
3. SEX	4. RACE	S. DATE OF BIRTH	6. AGE (In years at birthday) 56 yrs		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	2c. DATE PRONOUNCED DEAD Month 12 Day 29 Year 1979				2d. HOUR 5:45 M
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. COUNTY OF DEATH Dorchester					
10. CITY OR TOWN OF DEATH Cambridge		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 300 High street		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Hospital attendant				12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13c. CITY OR TOWN Cambridge		13d. INSIDE CITY LIMITS <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER 300 High street					
14. FATHER'S NAME James		Middle L.	Last Cranfield	15. MOTHER'S MAIDEN NAME Nellie							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) YES W.W. 2 570-32-0242		17. INFORMANT Charles L. Cranfill		ADDRESS Buxton, N.C.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH sudden 410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) _____ stating the underlying cause (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Lawrence Maryanov</i>		EXAMINER'S NAME (Type) Lawrence Maryanov, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 12/31/79			
23a. BURIAL, CREMATION, REMOVAL (Specify) cremation		23b. DATE Dec. 31, 1979		23c. NAME OF CEMETERY OR CREMATORIAL Delmarva Crematory		23d. LOCATION (City or Town) (County) (State) Lewes, Sussex, Del.		ADDRESS (Street, city, town, or county) 610 Race St. Cambridge, Md. 21613			
24. FUNERAL DIRECTOR Thomas Funeral Home, Cambridge, Md.		ADDRESS		25a. REC'D BY REGISTRAR JAN 7 1980		25b. REGISTRAR'S SIGNATURE <i>Henry McCreary</i>					

x

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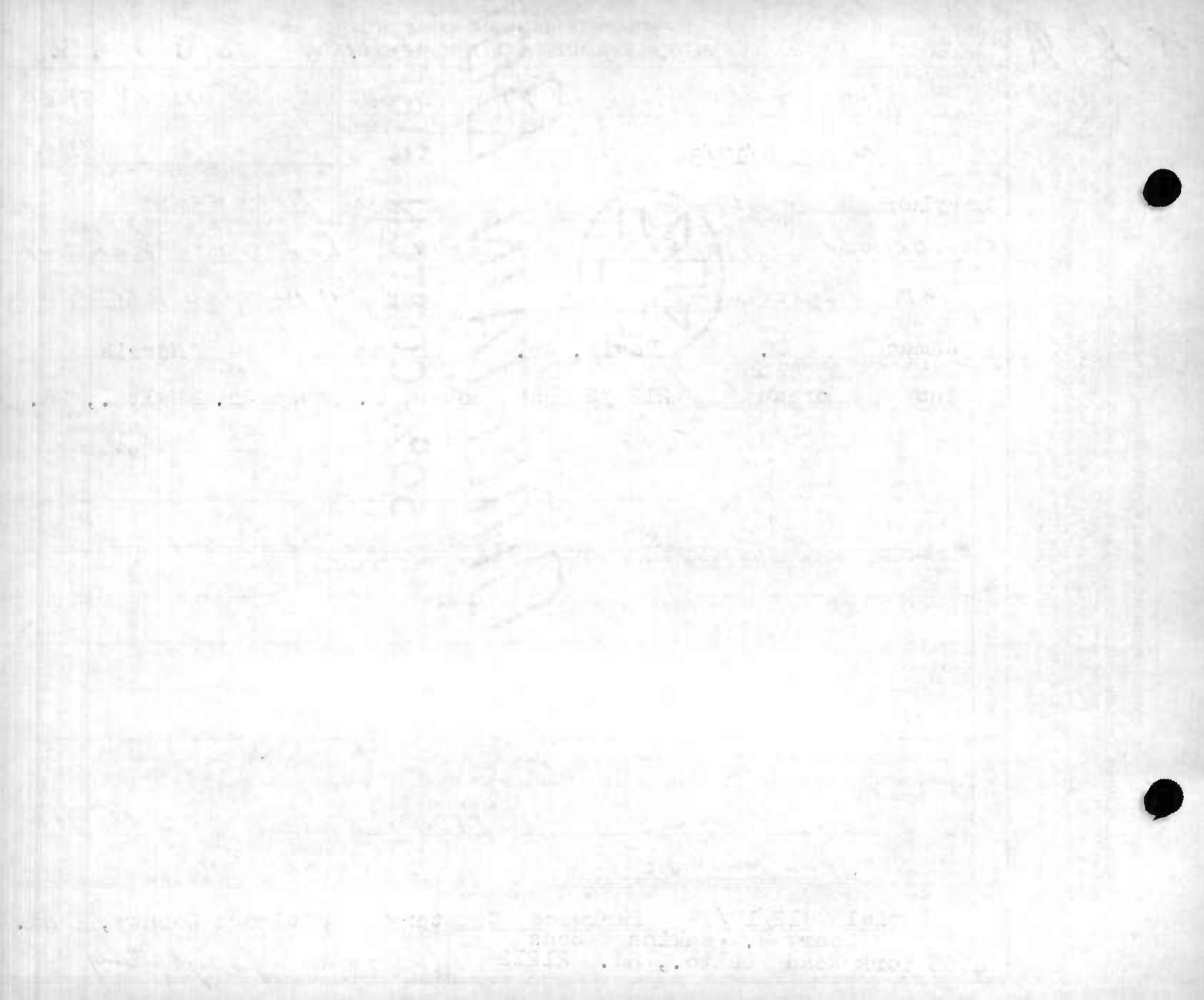
x



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 8, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL/TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 30942			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED			MONTH	DAY	YEAR	2b. HOUR			
<i>ROBERT</i>			<i>R</i>	<i>DAVIS SR.</i>		<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	12	13	1979	6PM			
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD			MONTH	DAY	YEAR	2d. HOUR			
<i>M</i>	<i>W</i>	<i>4/17/36</i>	<i>43 yrs.</i>			<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<i>12</i>	<i>19</i>	<i>79</i>	<i>6PM</i>			
10. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED			9. BALTIMORE CITY OR COUNTY OF DEATH						
<i>Maryland</i>			<i>U.S.A.</i>			<input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED			<i>DORCHESTER</i>						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
<i>CAMBRIDGE</i>			<i>DORCHESTER GENERAL</i>			<i>PLUMBER</i>			<i>PLUMBING</i>						
13a. STATE			13b. COUNTY			13c. CITY OF TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS			
<i>MD</i>			<i>BALTIMORE</i>			<i>Parkville</i>						<i>6911 HARFORD RD</i>			
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST												
<i>James L. Davis, Jr.</i>			<i>Pronne Norris</i>												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS						
<i>Yes Korean</i>			<i>212 32 5444</i>			<i>Robert R. Davis Jr.</i>			<i>Balto., Md.</i>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
IMMEDIATE CAUSE (a) <i>CORONARY OCCLUSION</i> DUE TO, OR AS A CONSEQUENCE OF { (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												<i>few min.</i>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?									
												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												TITLE (SPECIFY) <i>John Mace Jr.</i>			
EXAMINER'S NAME (TYPE OR PRINT) <i>JOHN MACE JR.</i>												MEDICAL EXAMINER <i>M.D. DEPUTY</i>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial 12/17/79 Parkwood Cemetery Baltimore County, Md.												ADDRESS <i>CAMBRIDGE, MD.</i>			
24. FUNERAL DIRECTOR NAME <i>Henry W. Jenkins & Sons</i> ADDRESS <i>4905 York Road Balto., Md. 21212</i>												25a. DATE REC'D. BY REGISTRAR DEC 17 1979		25b. REGISTRAR'S SIGNATURE <i>Gerry McElroy</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours along with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 30943		
1 - FOR STATE REGISTRAR			2a DATE OF DEATH MONTH DAY YEAR						2b HOUR					
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST			Dec. 8 1979					
Nancy Elizabeth Dayton														
3. SEX female			4. RACE white			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY) 65					
						March 27 1914			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester					
10. CITY OR TOWN OF DEATH Cambridge			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) secretary-insurance			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Md.			13b. COUNTY Dor.			13c. CITY OR TOWN Cambridge			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 109 Belvedere Ave.		
14. FATHER'S NAME FIRST William MIDDLE L. LAST Dean			15. MOTHER'S MAIDEN NAME FIRST Nancy MIDDLE						LAST Robbins					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no			16b. SOCIAL SECURITY NO. 214-07-7093			17. INFORMANT Mowbray L. Dayton			ADDRESS Item #13					
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>410-</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>SEVERE CORONARY ARTERY DISEASE</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 DAYS - TERMINAL		
DUE TO, OR AS A CONSEQUENCE OF (c) <i>ARTERIOSCLEROTIC HEART DISEASE</i>												1+ yrs		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>HYPERTENSIVE CARDIOVASCULAR DISEASE</i>												1+ yrs		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from <i>Dec 8 1979</i> to <i>Dec 8 1979</i> , that (I) (we) last saw the deceased alive on <i>Dec 8 1979</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did <i>not</i> view the body after death.												22c. DATE SIGNED 12-8-79		
22b. SIGNATURE <i>Donald R. McWilliams</i>			22d. DEGREE M.D.						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Donald R. McWilliams, M.D.</i>			22f. ADDRESS <i>308 GAY ST. CAMBRIDGE, MD. 21613</i>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial			23b. DATE 12/11/79			23c. NAME OF CEMETERY OR CREMATORIAL Dor. Mem. Park			23d. LOCATION CITY OR TOWN Cambridge COUNTY Dor. STATE Md.					
24. FUNERAL DIRECTOR Thomas Funeral Home			25a. BOX No. 348 Cambridge Md.			25b. DATE REC'D. BY REGISTRAR DEC 14 1979			25b. REGISTRAR'S SIGNATURE <i>Larry McCready</i>					

1970-71 1971-72 1972-73 1973-74

1974-75 1975-76 1976-77 1977-78

1978-79 1979-80 1980-81 1981-82

1982-83 1983-84 1984-85 1985-86

1986-87 1987-88 1988-89 1989-90

1990-91 1991-92 1992-93 1993-94

1994-95 1995-96 1996-97 1997-98

1998-99 1999-2000 2000-2001 2001-2002

2002-03 2003-04 2004-05 2005-06

2006-07 2007-08 2008-09 2009-10

2010-11 2011-12 2012-13 2013-14

2014-15 2015-16 2016-17 2017-18

2018-19 2019-20 2020-21 2021-22

2022-23 2023-24 2024-25 2025-26

2026-27 2027-28 2028-29 2029-30

2030-31 2031-32 2032-33 2033-34

2034-35 2035-36 2036-37 2037-38

2038-39 2039-40 2040-41 2041-42

2042-43 2043-44 2044-45 2045-46

2046-47 2047-48 2048-49 2049-50

2050-51 2051-52 2052-53 2053-54

2054-55 2055-56 2056-57 2057-58

2058-59 2059-60 2060-61 2061-62

2062-63 2063-64 2064-65 2065-66

2066-67 2067-68 2068-69 2069-70

2070-71 2071-72 2072-73 2073-74

2074-75 2075-76 2076-77 2077-78

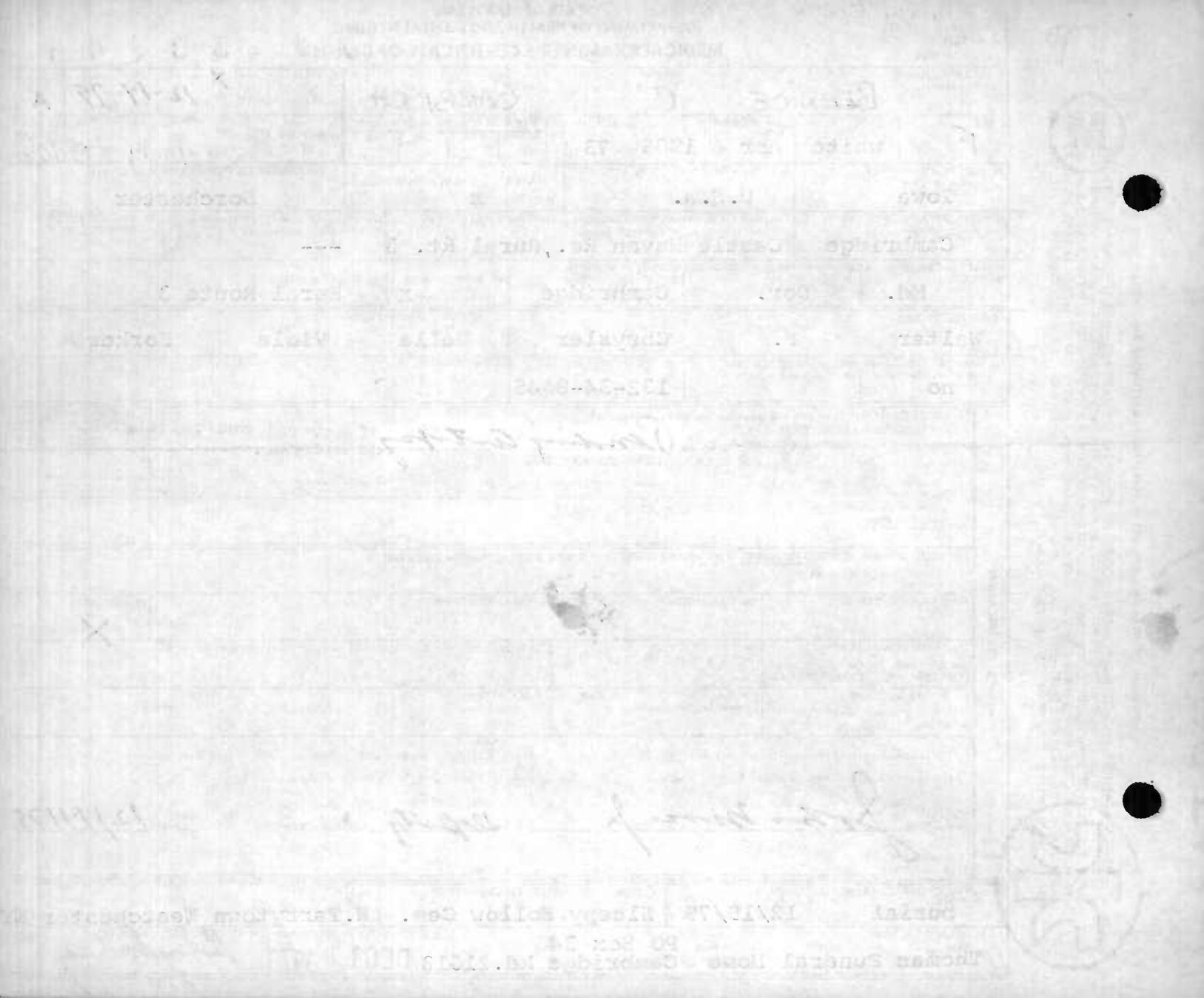
2078-79 2079-80 2080-81 2081-82

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, WRITE THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.

PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3, RETAIN PAGE 5 FOR FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 30944		
1. DECEASED NAME (TYPE OR PRINT)				FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED				MONTH	DAY	YEAR	2b. HOUR
BERNICE				C.		GARBISCH	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	12	14	79	A M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS) LAST BIRTHDAY	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD				MONTH	DAY	YEAR	2d. HOUR	
F	white	Apr 4 1906	73 yrs.			<input type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	12	14	79	10 AM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH					
Iowa		U.S.A.							Dorchester MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY					
Cambridge		Castle Haven Rd., Rural Rt. 3												
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE Md.			13b. COUNTY Dor.		13c. CITY OR TOWN Cambridge		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS Rural Route 3			
14. FATHER'S NAME		FIRST Walter	MIDDLE P.	LAST Chrysler	15. MOTHER'S MAIDEN NAME FIRST Della				MIDDLE Viola	LAST Forker				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT				ADDRESS					
no		132-34-8645												
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ 9505 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____												unknown		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY?		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER		
ACTUAL SIGNATURE EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS									DATE SIGNED 12/14/79		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE burial 12/19/79			23c. NAME OF CEMETERY OR CREMATORIAL Sleepy Hollow Cem.			23d. LOCATION CITY OR TOWN W. Tarrytown			COUNTY	STATE	
24. FUNERAL DIRECTOR NAME Thomas Funeral Home			ADDRESS PO Box 348 Cambridge Md. 21613			25a. DATE REC'D. BY REGISTRAR 13 DEC 18 1979			25b. REGISTRAR'S SIGNATURE Henry McCreedy					
DHMH - 17 (VR A15 ME (5)) 15M 7/77														



MARYLAND STATE DEPARTMENT OF HEALTH

FOR STATE
HEALTH DEPT.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1 and 2 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form S may be retained for your files. W. J. G.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print)			First	Middle	Lost	2a. DATE KNOWN OF ESTI- DEATH MATED	Month	Day	Year	2b. PUR	
Edgar			W.	Garbisch		<input checked="" type="checkbox"/>	Dec.13	79	10 40		
3. SEX	4. RACE	S. DATE OF BIRTH	6. AGE (in years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.						
Male	White	Apr. 7, 1899	80 YRS.	MONTHS	DAYS	HOURS	MIN.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH		2c. DATE PRONOUNCED DEAD			
Indiana		U.S.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Dorchester		Month	12 Day 13 Year 1979	2d. HOUR M	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Cambridge			Dorchester Genl. Hospital			Retired					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET AND NUMBER		
Md.			Dor.			Cambridge			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	Rural R.D.3	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			First			Middle	Last	
Henry			Garbisch			Sophia Carolina			Schwartz		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
YES W.W.I			(If you gave name or dates of service)			065-09-8493 Edw. Garbisch			St. Michaels, Md., 21663		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>CORONARY OCCLUSION</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(b) <u>ARTERIO SCLEROTIC C.V.</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
<u>few min</u>											
<u>few yrs</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			YES <input type="checkbox"/> NO <input type="checkbox"/>		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>John Garbisch</u>											
EXAMINEE NAME (Type)											
CHIEF MEDICAL EXAMINER <input type="checkbox"/>											
M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>											
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>											
ADDRESS(Street, city, town, or county)											
22b. DATE SIGNED <u>12/14/79</u>											
23a. BURIAL, CREMATION, REMOVAL(Specify) burial		23b. DATE 12/19/79		23c. NAME OF CEMETERY OR CREMATORIAL Sleepy Hollow Cem.			23d. LOCATION (City or Town) W.Tarrytown		(County) Westchester		(State)
24. FUNERAL DIRECTOR Thomas Funeral Home		ADDRESS PO Box 348 Cambridge Md. 21616			25a. REC'D. BY REGISTRAR DEC 18 1979		25b. OFFICIAL'S SIGNATURE John Garbisch				



MARYLAND STATE DEPARTMENT OF HEALTH

9 30946



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial/transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation or removal and in any event within 24 hours after death.

5 may be retained for your files.

1. DECEASED NAME (Type or Print)				First George	Middle Edward	Last Harrison	20. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 12-21-1979 A.M.	Month Day Year	2b. HOUR 2d. HOUR 10 20 A.M.
3. SEX Male	4. RACE White	5. DATE OF BIRTH Aug. 2, 1926	6. AGE (In years last birthday) 53 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c. DATE PRONOUNCED DEAD Month 12-	Day 21	Year 1979	
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.	B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH Dorchester						
10. CITY OR TOWN OF DEATH Taylor Island	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Home, Taylor Island	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Merchant	12b. KIND OF BUSINESS OR INDUSTRY Grocery						
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.	13c. CITY OR TOWN Dor.	13d. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER Rural						
14. FATHER'S NAME George	First Middle E. Harrison	15. MOTHER'S MAIDEN NAME Carolyn Matilda Waters							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES	16b. SOCIAL SECURITY NO. W.W.2	17. INFORMANT Mrs. Mary Linda Gray,	ADDRESS Cambridge, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (o) <u>410</u>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Coronary occlusion Few Min.</u>					
Conditions, if any, which gave rise to immediate cause (o), stating the underlying cause <u>410</u>				DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1b)					
21d. INJURY OCCURRED		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town	County	State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <i>John Mace Jr.</i> EXAMINER'S NAME (Type) John Mace Jr.									
CHIEF MEDICAL EXAMINER <input type="checkbox"/> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Dec. 23, 1979		23c. NAME OF CEMETERY OR CREMATORIAL Dorchester Mem. Park		23d. LOCATION (City or Town) (County) (State) Cambridge Dor., Md.			
24. FUNERAL DIRECTOR Thomas Funeral Home, Cambridge, Md.		ADDRESS		25a. REC'D. BY REGISTRAR JAN 7 1980		25b. SIGNATURE			



BOSTON PUBLIC LIBRARY

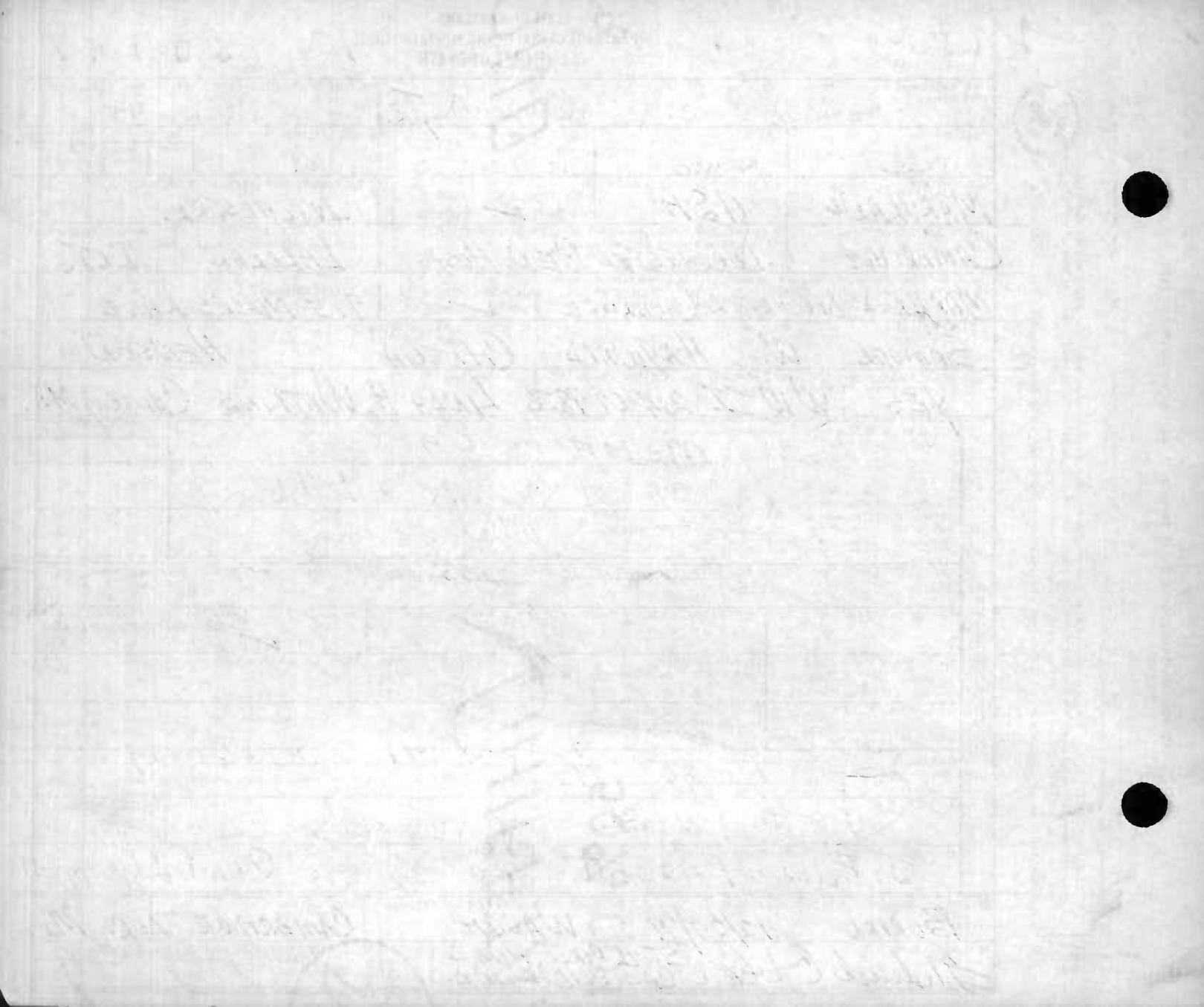
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 7930947	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
<i>Samuel W. Hayward, Jr.</i>						12 26 79						M	
3. SEX			RACE	5. DATE OF BIRTH			6. AGE [IN YEARS LAST BIRTHDAY]			IF UNDER 1 YEAR			
Male			Negro	MONTH DAY YEAR			69			IF UNDER 24 HRS			
7a. BIRTHPLACE COUNTRY			7b. CITIZEN OR WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
MARYLAND			USA						DOVER				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
CAMBRIDGE			DOVER			LABORER			RETI.				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13. STATE			14. COUNTY			15. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS	
MARYLAND			DOVER			CAMBRIDGE						915 MACES LANE	
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME							
SAMUEL W. HAYWARD						CORNELIA							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
YES			WV 02 214-07-7838			Linda H. WATKINS			Cambridge, Md.				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
1619 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, last													
{ DUE TO, OR AS A CONSEQUENCE OF (b) CA of Aneryxx + left lower { DUE TO, OR AS A CONSEQUENCE OF (c) lobes of lung													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE	
22a. I certify that (I) (this hospital) attended the deceased from 12-9-79 to 12-26-79, that (I) (we) last saw the deceased alive on 12-26-79, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (do not) view the body after death.												22c. DATE SIGNED	
22b. SIGNATURE <i>J. Edwin Fassett</i>			22c. DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS PO. Box 576 Cambridge, Md.										
23a. BURIAL, CREMATION, REMOVAL			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL ESTATE			23d. LOCATION CITY OR TOWN			COUNTY	
BURIAL			12/29/79			WAUGH			CAMBRIDGE			SO. MD.	
24. FUNERAL DIRECTOR <i>Frederick Blair</i>			ST. CLAIR F. HOME CAMBRIDGE, MD.			25a. DATE REC'D. BY REGISTRAR JAN 10 1980			25b. REGISTRAR'S SIGNATURE <i>Frederick Blair</i>				

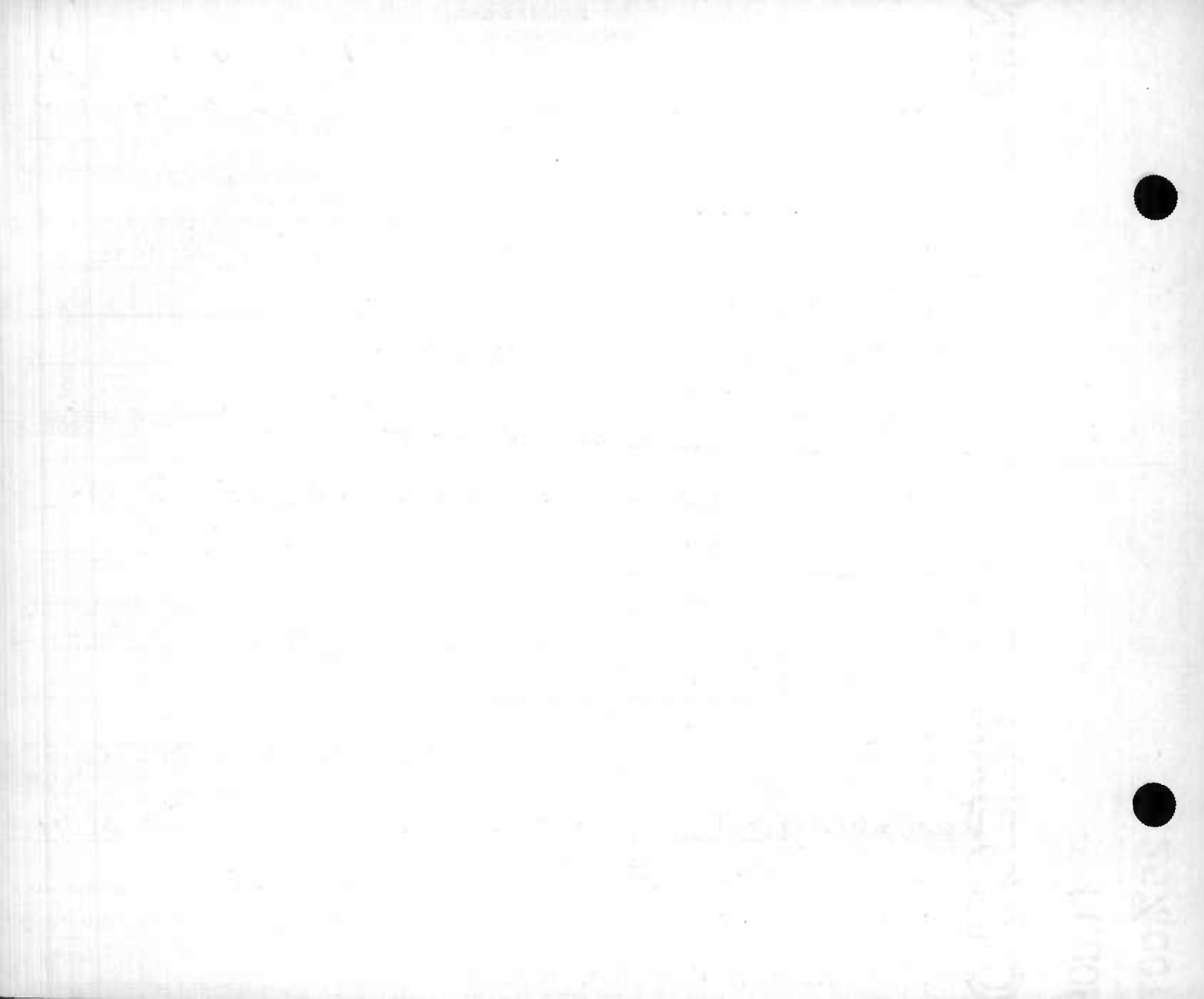


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.					
1 - STATE REGISTRAR						7 9 3 0 9 4 8											
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR					
George					Jackson	12 31 79						6:16 PM					
3. SEX			4 RACE	5 DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS					
Male			Negro	Month Dec. 29, 1905 Year			74			MONTHS	YEARS	HOURS	MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH								
Dorchester Co., Md.			U.S.A.						Dorchester			MD.					
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Cambridge			Dorchester General Hospital			Farmer - Chesterfield Farms											
13a. STATE			13b. COUNTY			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS								
Maryland			Dorchester			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			RFD								
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME														
FIRST Alexander Johnson			MIDDLE			LAST			FIRST Elizabeth Jackson			LAST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17 INFORMANT			ADDRESS								
No			219-14-4571A			Rachel Johnson, PO Box 156, Hurlock, Md.						21643					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIAC ARREST													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
4409 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) CONGESTIVE HEART FAILURE													2 WK				
{ DUE TO, OR AS A CONSEQUENCE OF (c) ATHEROSCLEROTIC VASCULAR DISEASE													?				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
/			/						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			/			/					
/			P.M. 19			/			/			/					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE			
22a. I certify that (I) (we) attended the deceased from 12-30			1979			to 12-31			1979			that (I) (we) last					
saw the deceased alive on 12-31 1979			and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.			/			/			/					
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED			12-31-79					
Michael A. Maskewicz Jr.																	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			/			/			/			/		
Michael A. Maskewicz Jr.			6 Superior St.			/			/			/			/		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY		STATE			
Burial			Jan. 5, 1980			Petersburg Cemetery			Hurlock, Dorchester, Maryland								
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE								
Frampton - Hawkins			Box 43 Fed, md 21632			JAN 1980			John C. Brady								

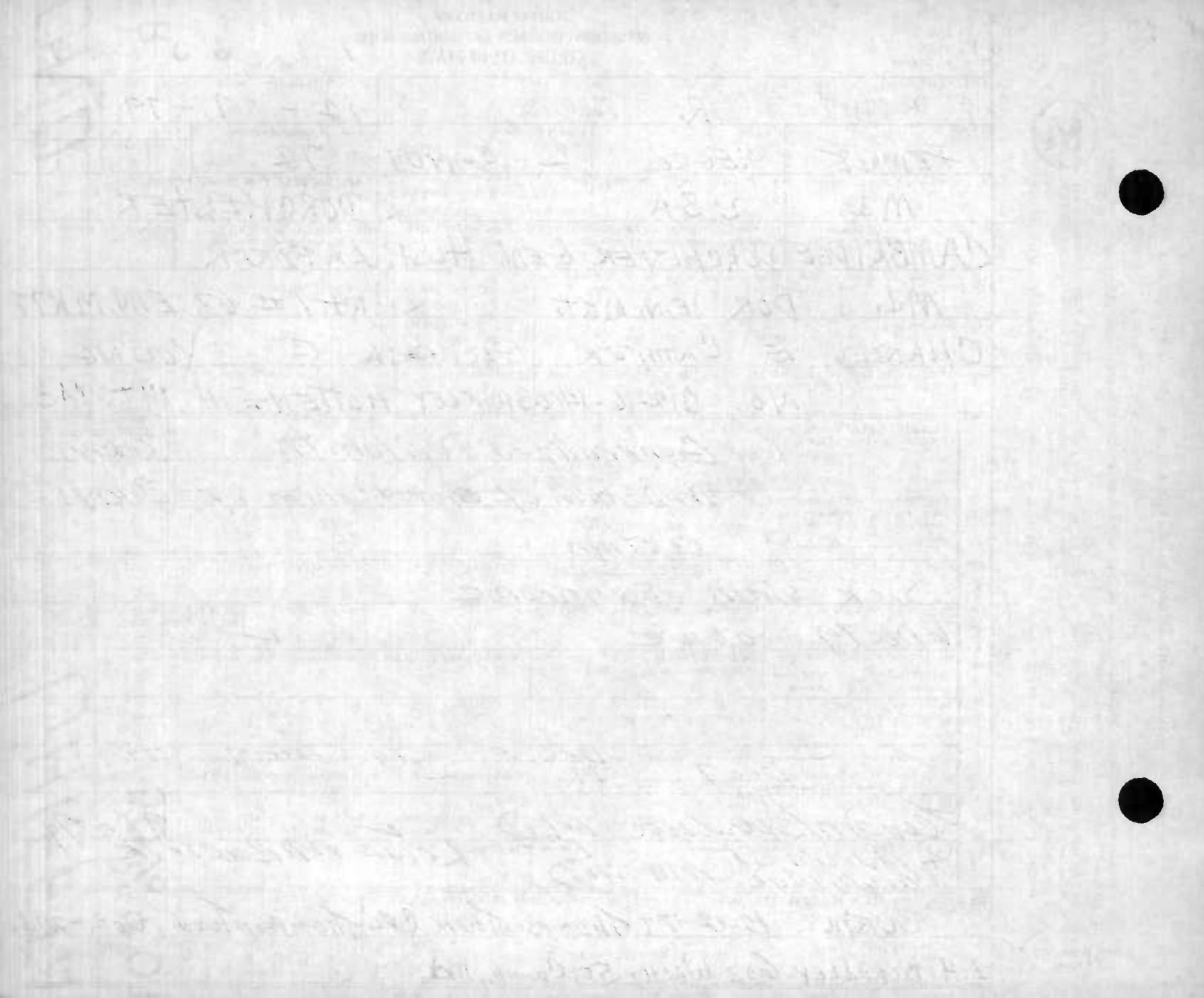


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours and sent with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 7930949		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
HELEN R. Johnson						12 - 1 - 79								
3. SEX			4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		
FEMALE			NEGRO		2 - 18 - 1907		72							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8.		9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
Md.			USA		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		DORCHESTER							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
CAMBRIDGE			DORCHESTER GEN. HOSP.		LABORER									
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS				
Md.			DOR		E.N. MKT.					RT. 1 # 63-E.N. MKT.				
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME								
CHARLES E. CAMPER						GEORGIA G. YOUNG								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
NO			212-16-1460		SHIRLEY HOTTEN-E.N. MKT. Md.							30 days		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Generalized Peritonitis</u> 30 days														
5621 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Perforation of Diverticulum of rectum</u> 3 days														
DUE TO, OR AS A CONSEQUENCE OF (c) <u>rectum</u>														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Sick sinus syndrome</u>														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
6 Dec 79			above			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
			P.M. 19											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (the hospital) attended the deceased from <u>Dec 5</u> , 19 <u>79</u> , to <u>Dec 7</u> , 19 <u>79</u> , that (I) (we) last saw the deceased alive on <u>Dec 7</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED					
Lewis McButter MD									17 Dec 79					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			Lewis McButter								
A. Huron St Cambridge, MD 21613														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY		STATE
BURIAL			12-12-79			Thompson Town Cr. Thompson Town			Dor. Md.					
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
L.H. BOARDREY 603 Wash. St. Camb., Md.						DEC 13 1979								

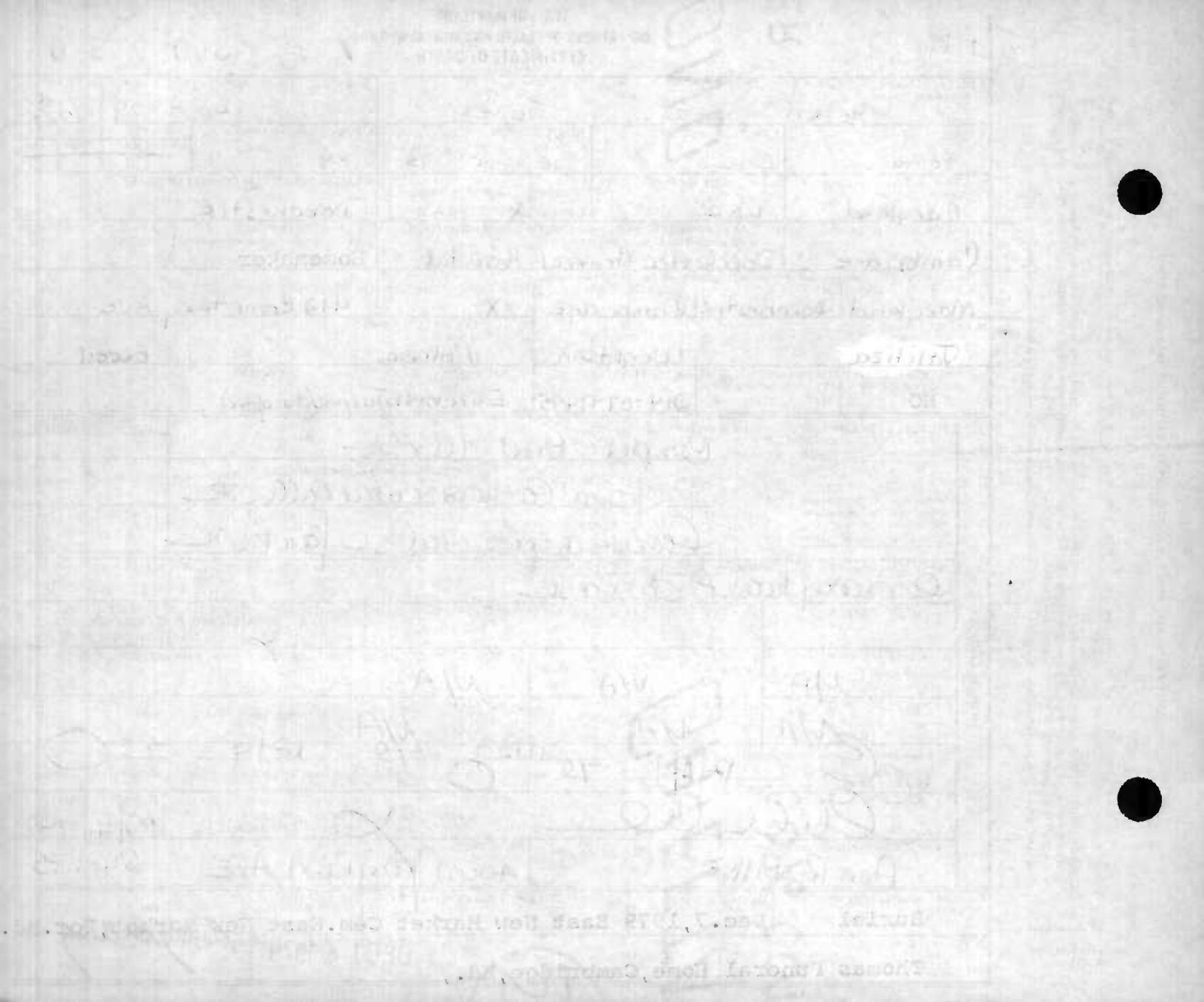


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the offending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 7 9 3 0 9 5 0				
1. DECEASED NAME (TYPE OR PRINT)				MIDDLE	LAST	2d. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR				
Helen E. Jones						12 4 79						6:50 PM				
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN			
Female		Cau.		10 30 95			84									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		USA									Dorchester					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				
Cambridge		Dorchester General Hospital										Homemaker				
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS							
Maryland		Dorchester		Cambridge					412 Cemetery Ave							
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST														
Joshua		Victoria														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS										
NO		214-67-9495		Elizabeth Turner (daughter)												
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Complete heart block -</u> <u>410 -</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Severe cardiovascular collapse</u> (c) <u>Acute myocardial infarction</u>													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Coronary heart disease</u>																
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. N/A 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			N/A		N/A						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREETS, FACTORY, OFFICE, FARM, ETC.) N/A			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			N/A		N/A						
22a. I certify that (I) (we) attended the deceased from <u>11/27/79</u> to <u>12/4/79</u> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated below. If necessary, give address above (I) (we) did not view the body after death.																
22b. SIGNATURE		DEGREE										ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS										12/4/79		2/6/83		
Ann R. Wilke.		400 Maryland Ave														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORI			23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE					
Burial		Dec. 7, 1979		East New Market Cem.			East New Market		Dor. Md.							
24 FUNERAL DIRECTOR NAME		ADDRESS										25a. DATE REC'D. BY RECORDAR		25b. DATE OF DEATH		
Thomas Funeral Home, Cambridge, Md.												DEC 14 1979				

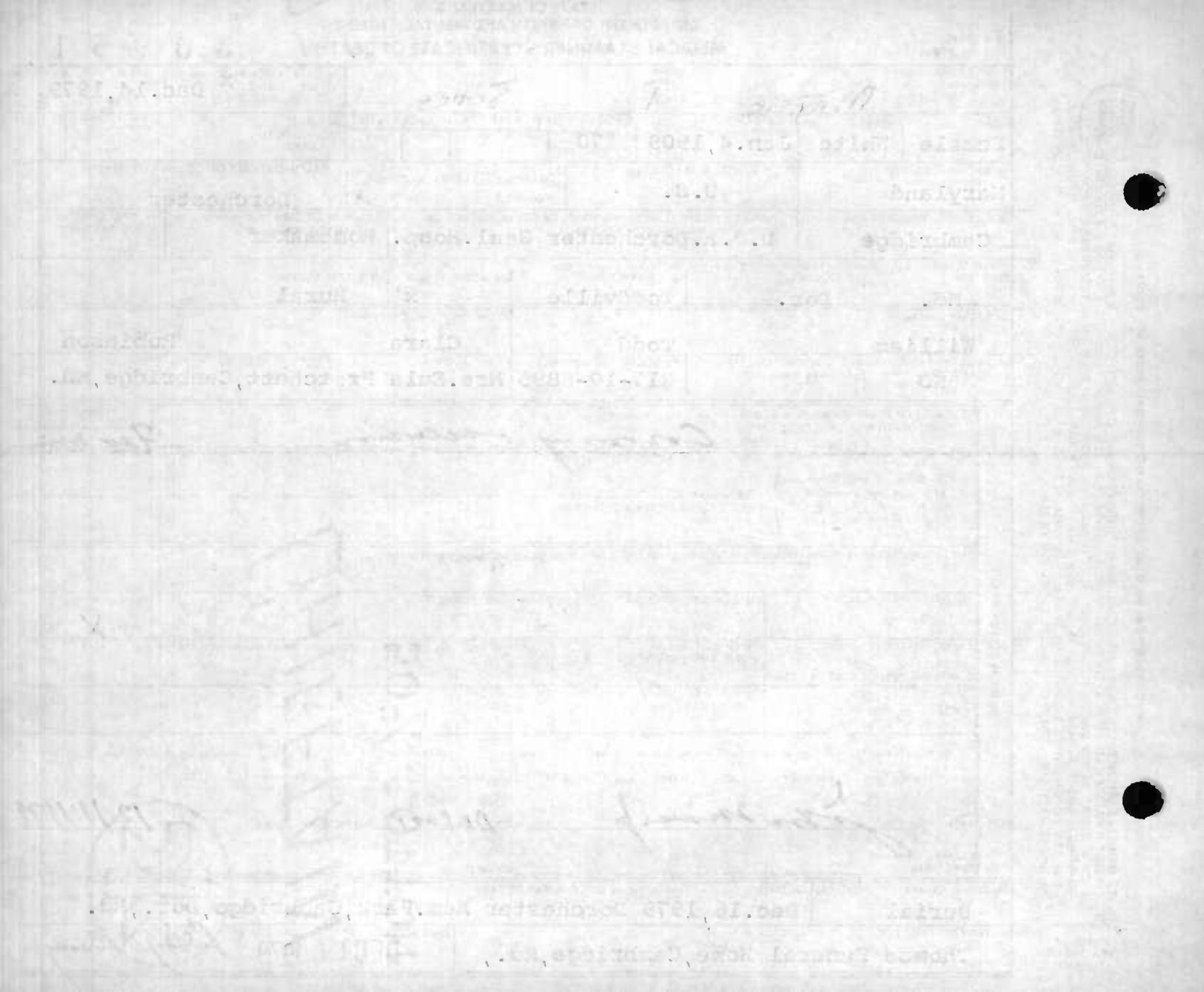


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, AND 3 TO THE FUNERAL DIRECTOR.

PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 3, RETAIN PAGE 5 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION OR REMOVAL.

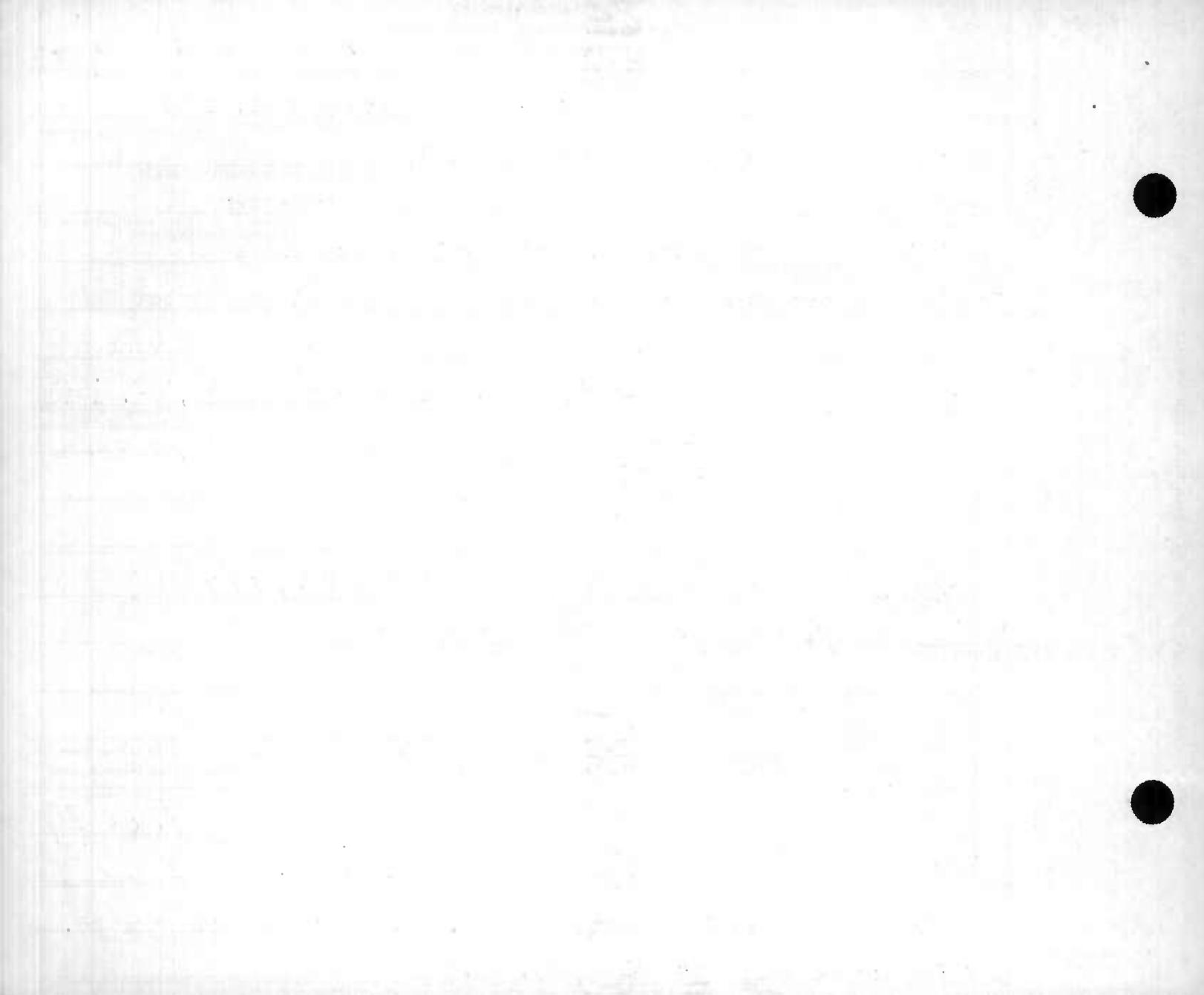
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH ⁹												REG. 30951							
1- STATE REGISTRAR			2a. DATE KNOWN OF ESTI- DEATH MATED									2b. HOUR							
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			<input checked="" type="checkbox"/> Dec. 14, 1979		A 6 M					
Maysie R. Jones																			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR		2d. HOUR			
Female		White		Jan. 4, 1909			70 yrs.							19		M			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH										
Maryland			U.S.						Dorchester						MD.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK) (FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Cambridge			D.O.A. Dorchester Genl. Hosp.									Homemaker							
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS					
			Md.			Dor.			Toddville					Rural					
14. FATHER'S NAME FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST						LAST				
William						Todd			Clara						Robinson				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			16c. INFORMANT			ADDRESS										
NO			217-10-8895			Mrs. Eula Pritchett, Cambridge, Md.													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART I DEATH WAS CAUSED BY:												Few min							
IMMEDIATE CAUSE (a) <i>Coronary occlusion</i> DUE TO, OR AS A CONSEQUENCE OF																			
410- Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.																			
(b) _____ DUE TO, OR AS A CONSEQUENCE OF																			
(c) _____																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY?							
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET						CITY OR TOWN		COUNTY		STATE			
22a. I certify that I took charge of the remains described above, held on _____ Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												TITLE (SPECIFY)							
ACTUAL SIGNATURE <i>John Murphy</i>												M.D. <i>Deputy</i> MEDICAL EXAMINER				DATE SIGNED <i>12/14/79</i>			
EXAMINER'S NAME (TYPE OR PRINT)												ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORI			23d. LOCATION CITY & TOWN			COUNTY		STATE					
Burial			Dec. 16, 1979			Dorchester Mem. Park, Cambridge, Dor., Md.													
24. FUNERAL DIRECTOR NAME			ADDRESS						25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE							
Thomas Funeral Home, Cambridge, Md.,									DEC 18 1979			<i>Hector McCrady</i>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 7930952										
1 - STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)				FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR				
			SUE								LEMMON		December 1, 1979									
3. SEX			4. RACE				5. DATE OF BIRTH				6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS							
female			white				MONTH DAY YEAR				MAY 15, 1889		MONTHS DAYS		HOURS MIN							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?				MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH				MD.							
Maryland			USA								Dorchester											
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY											
Cambridge			Dorchester General Hospital				housewife															
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												13a. STREET ADDRESS										
13a. STATE			13b. COUNTY				13c. CITY OR TOWN				YES <input checked="" type="checkbox"/>		NO <input type="checkbox"/>		504 Eighth Street							
Maryland			Worcester				Pocomoke															
14. FATHER'S NAME			FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		FIRST		MIDDLE		LAST							
			George		Lee		Seville		Sally		Ann				Stevenson							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS											
no			J1 209-40-3631				Anne Greene				Hopkins House, Apt. 604 Philadelphia, Pa. 19106											
II. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
436- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												minutes										
Cerebrovascular accident																						
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis																						
DUE TO, OR AS A CONSEQUENCE OF (c)																						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																						
Amputation, above knee left Nov 23, 1979			18b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
18a. DATE OF OPERATION			18b. CONDITON FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				YES <input type="checkbox"/> NO <input type="checkbox"/>							
Nov 23, 1979			Congenital foot + leg																			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)				22a. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
											YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				YES <input type="checkbox"/> NO <input type="checkbox"/>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET				CITY OR TOWN				COUNTY		STATE					
22a. I certify that (I) (this hospital) attended the deceased from Aug 1978 to Dec 1, 1979, that (I) (we) last saw the deceased alive on Dec 1, 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.																						
22b. SIGNATURE			DEGREE				ATTENDING PHYSICIAN				MEDICAL DIRECTOR		STAFF PHYSICIAN		22c. DATE SIGNED							
Lewis M. Burlette MD															1 Dec 79							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS				23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE	
Lewis M. Burlette			4 Aurora St Cambridge, Md 21617				Burial				12/5/79		Bethany Meth. Cem.		Pocomoke		Worcester		Md.			
24. FUNERAL DIRECTOR NAME			ADDRESS				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE											
Scott S. Melon			Pocomoke City, Md.				NFC 5 1979															





FOR STATE
HEALTH DEPT.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 24 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET

PRO DEPUTY MEDICAL
If necessary, please execute
the funeral director. Pa-

VR A15ME (5)
10M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9 30953

1. DECEASED-NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN OF ESTI- DEATH MATED	Month	Day	Year	2b. HOUR				
Frederick John Miller						<input checked="" type="checkbox"/>	Dec. 2,	1979	4AM					
3. SEX	4. RACE	S. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. DAYS	HOURS	MIN	2c. DATE PRONOUNCED DEAD Month 12 Day 2 Year 1979			2d. HOUR 4A			
Male	White	Feb. 15, 1909	70 yrs.											
7b. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY	
Maryland		US				Dorchester		Cambridge			DOA Dorchester Gen. Hosp. Machinist			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		13b. COUNTY			14. FATHER'S NAME	First	Middle	Last
Maryland		Dorchester		Cambridge		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Cambridge			John	Milteer	Minnie	Stitely
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO. (If yes, give war or date of service)		17. INFORMANT		ADDRESS		15. MOTHER'S MAIDEN NAME						
Yes		WW II		212-07-4532 Mrs. Frederick J. Miller Item # 13				First			Middle	Last		
IB. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u>											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Few Min</u>			
410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF (c) _____														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.		City or Town		County		State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE <i>John Mace Jr.</i>		EXAMINER NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <u>12/2/79</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 12-4-79		23c. NAME OF CEMETERY OR CREMATORIAL Md. Veterans Cemetery		23d. LOCATION (City or Town) Beulah, Dor. Maryland		(County)		(State)				
24. FUNERAL DIRECTOR		ADDRESS Thomas Funeral Home Box 348 Maryland		25a. REC'D BY REGISTRAR Cambridge		25b. REGISTRAR'S SIGNATURE <i>Fifty McElroy</i>								

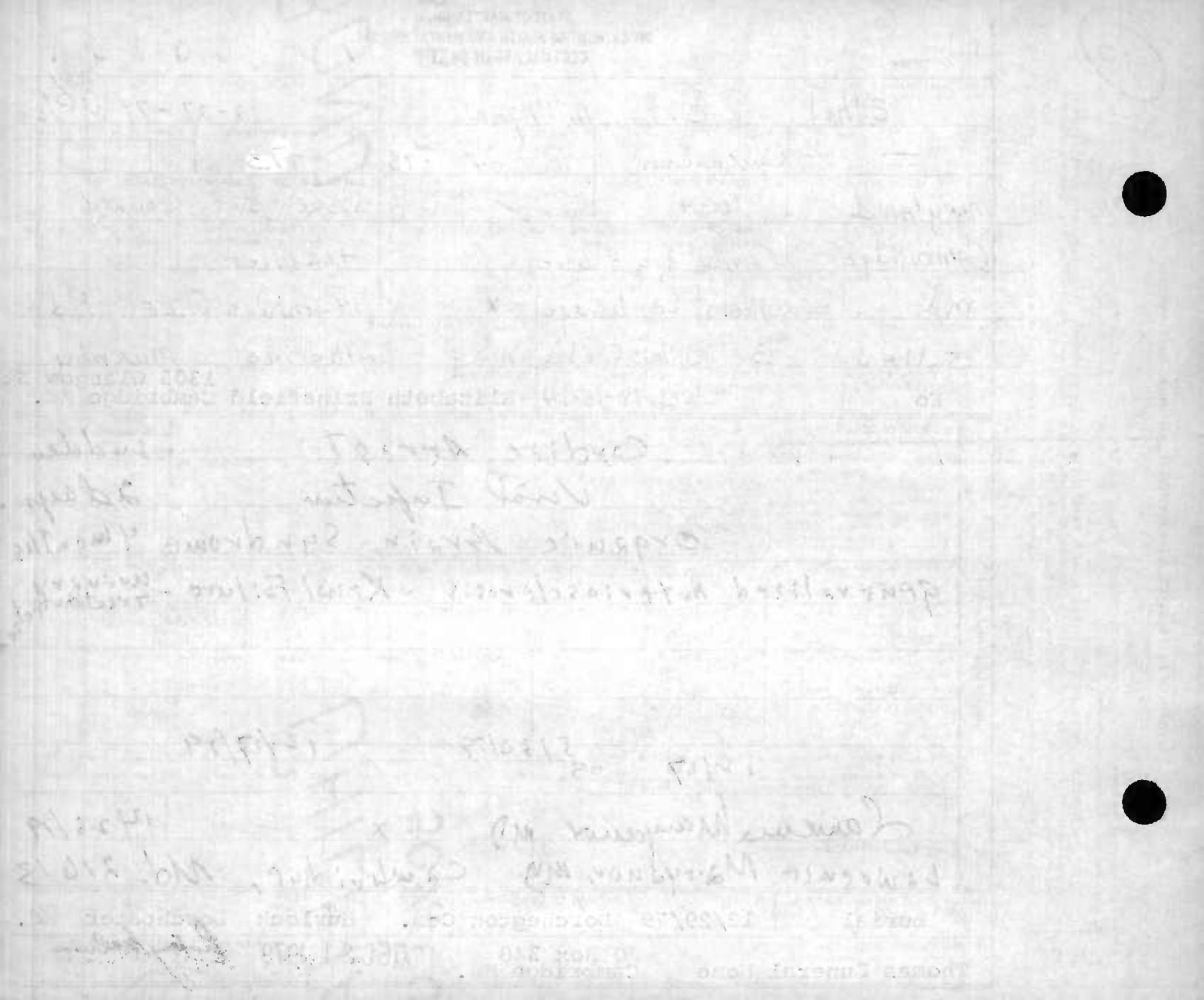
10-24 Печати съмъзжане
на този документ

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH														
10 79 30954 REG. NO.														
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR			
Ethel			B.	Milligan		12-27-79					1979			
2b. HOUR						12-27-79			AM					
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)					
F			Caucasian			MONTH	DAY	YEAR	74					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland			U.S.A.			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			Dorchester County MD.					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Cambridge			Cambridge House			Teacher								
13a. STATE			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS					
Md.			Dorchester Cambridge			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			14 Jenkins Creek Rd.					
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			ADDRESS					
Julian			B	Brinsfield		Mary Catherine Murphy			1305 Glasgow St					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Cambridge Md.					
No			213-14-1501A			Elizabeth Brinsfield								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>sudden</u>														
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost. (b) <u>Viral Infection</u> 2 days (c) <u>Organic Brain Syndrome</u> 4 months														
19. MEDICAL CERTIFICATION PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Generalized Arteriosclerosis - Renal Failure - Viral</u>														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>5/30/79</u> , 19 <u>79</u> , to <u>12/27/79</u> , 19 <u>79</u> .														
saw the deceased alive on <u>12/27</u> , 19 <u>79</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (not) view the body after death.														
22b. SIGNATURE <u>Lawrence Maryanow MD</u>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>1426/79</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Lawrence Maryanow, MD</u>			22e. ADDRESS <u>Cambridge, Md. 21613</u>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial			23b. DATE 12/29/79			23c. NAME OF CEMETERY OR CREMATORIAL Washington Cem.			23d. LOCATION CITY OR TOWN Hurlock			COUNTY Dorchester		
24. FUNERAL DIRECTOR NAME Thomas Funeral Home			ADDRESS PO Box 348 Cambridge Md.			25a. DATE REC'D. BY REGISTRAR DEC 31 1979			25b. DATE SIGNED <u>John Brady</u>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 7930955		
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
			Albert F Peak						12 31 79			M		
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
Male			2 - Neg			1 16 21			58			YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH		
South Carolina			U. S.									Dorchester		
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Cambridge			Dorchester General Hosp			Disabled								
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS		
Maryland			Dorchester			Preston						R1#2 Box 135		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST											
Furman			Hattie Mae Terrell											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
No			251-10-5760			Zelma A. Holland, Rt. 1, Box 135B, Preston,								
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Liver cirrhosis Laennec 5712 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Obstructive Lung disease.														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Car pneumonia														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from March 12 1975 to December 31 1977, that (I) (we) last saw the deceased alive on December 31 1979, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE Carlos F. Barruso			22c. DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 12-31-79					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CARLOS F. BARRUSO MD			22e. ADDRESS Hurlock Md. 21643											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Jan. 3, 1980			23c. NAME OF CEMETERY OR CREMATORIAL Federal Hill Cemetery			23d. LOCATION CITY OR TOWN Federalsburg, Caroline, Md.			COUNTY STATE		
24. FUNERAL DIRECTOR NAME Flempton-Hawkins			ADDRESS Box 43 Federalsburg			25a. DATE REC'D. BY REGISTRAR JAN 1980			25b. REGISTRAR'S SIGNATURE Flempton-Hawkins					

M



MARYLAND STATE DEPARTMENT OF HEALTH

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3 Page 5 may be retained for your files.

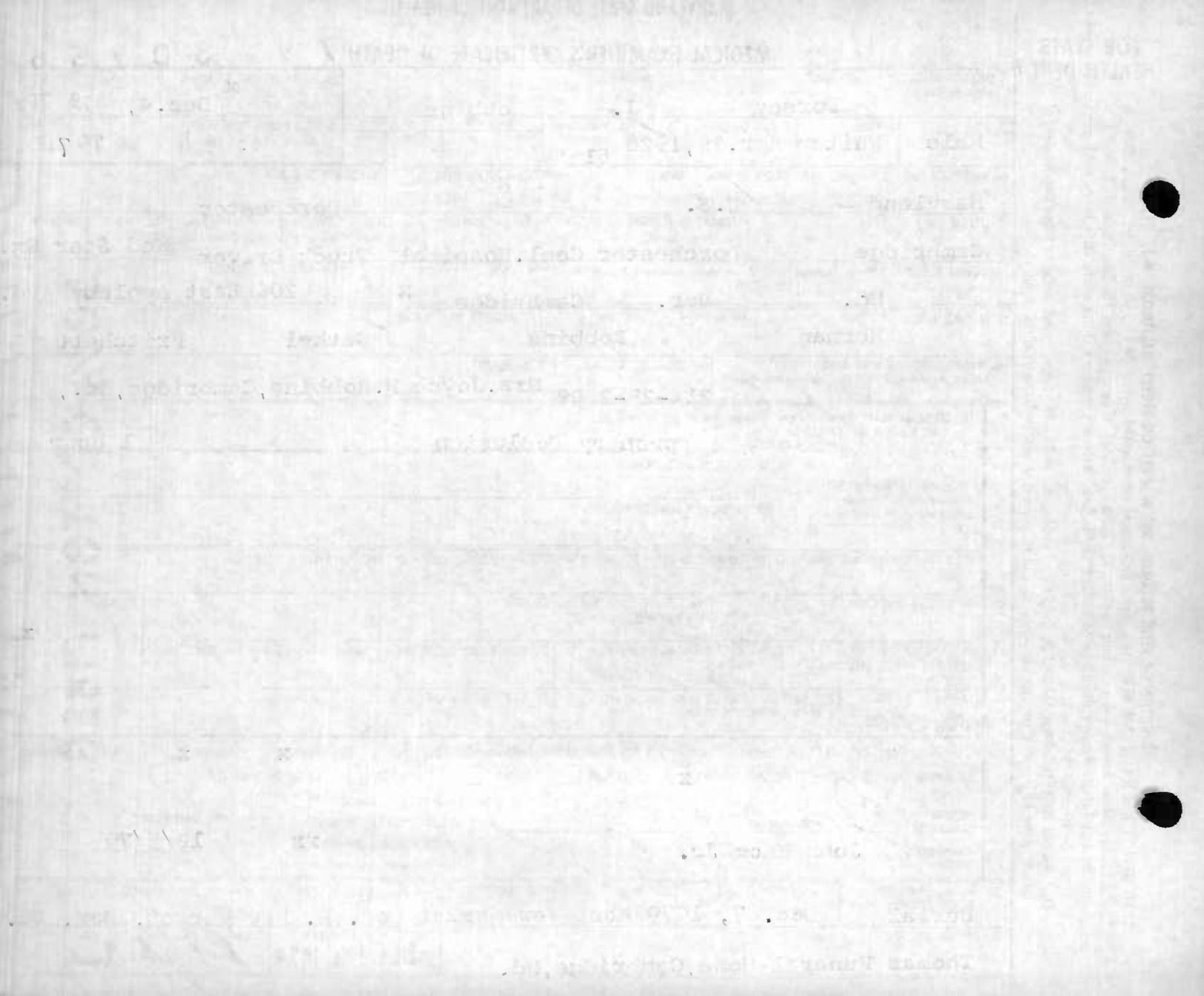
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1, 2, and 3 to the State Department of Vital Records, 301 W. PRESTON STREET, BALTIMORE, Md. 21202, with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

7 9

3 0 9 5 6

1. DECEASED NAME (Type or Print)		First	Middle	Last	2a. DATE KNOWN OF ESTI- DEATH MATED	Month	Day	Year	2b. HOUR	
		Dorsey	J.	Robbins	<input checked="" type="checkbox"/>	Dec. 4,	1979		7P M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS					
Male	White	Apr. 29, 1928	51 YRS.	MONTHS	DAYS	HOURS	MIN			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED	<input checked="" type="checkbox"/>	NEVER MARRIED	<input type="checkbox"/>	9. COUNTY OF DEATH		
Maryland		U.S.		WIDOWED	<input type="checkbox"/>	DIVORCED	<input type="checkbox"/>	Dorchester		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
Cambridge		Dorchester Genl. Hospital				Truck Driver			Red Star Ex.	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER				
Md.		Dor.		Cambridge		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		206 East Appleby Ave.		
14. FATHER'S NAME		First	Middle	Lost	15. MOTHER'S MAIDEN NAME	First	Middle	Lost		
		Herman			Robbins	Gethel			Pritchett	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS	
(If yes give war or dates of service)			214-28-2909			Mrs. Joyce H. Robbins, Cambridge, Md.,				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cronary Occlusion</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
410 - Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause</u> } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF										1 hour
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____				
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <i>John Mace Jr.</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>								
EXAMINER'S NAME (Type) John Mace Jr.		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>								22b. DATE SIGNED 12/5/79
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ADDRESS (Street, city, town, or county)										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Dec. 7, 1979		23c. NAME OF CEMETERY OR CREMATORIAL East New Market Cem. E. New Market, Dor., Md.			23d. LOCATION (City or Town) (County) (State)			
24. FUNERAL DIRECTOR		ADDRESS Thomas Funeral Home, Cambridge, Md.		25a. REC'D BY REGISTRAR DATE DEC 14 1979			25b. REC'D TRAR'S SIGNATURE <i>Rufus J. McCloskey</i>			

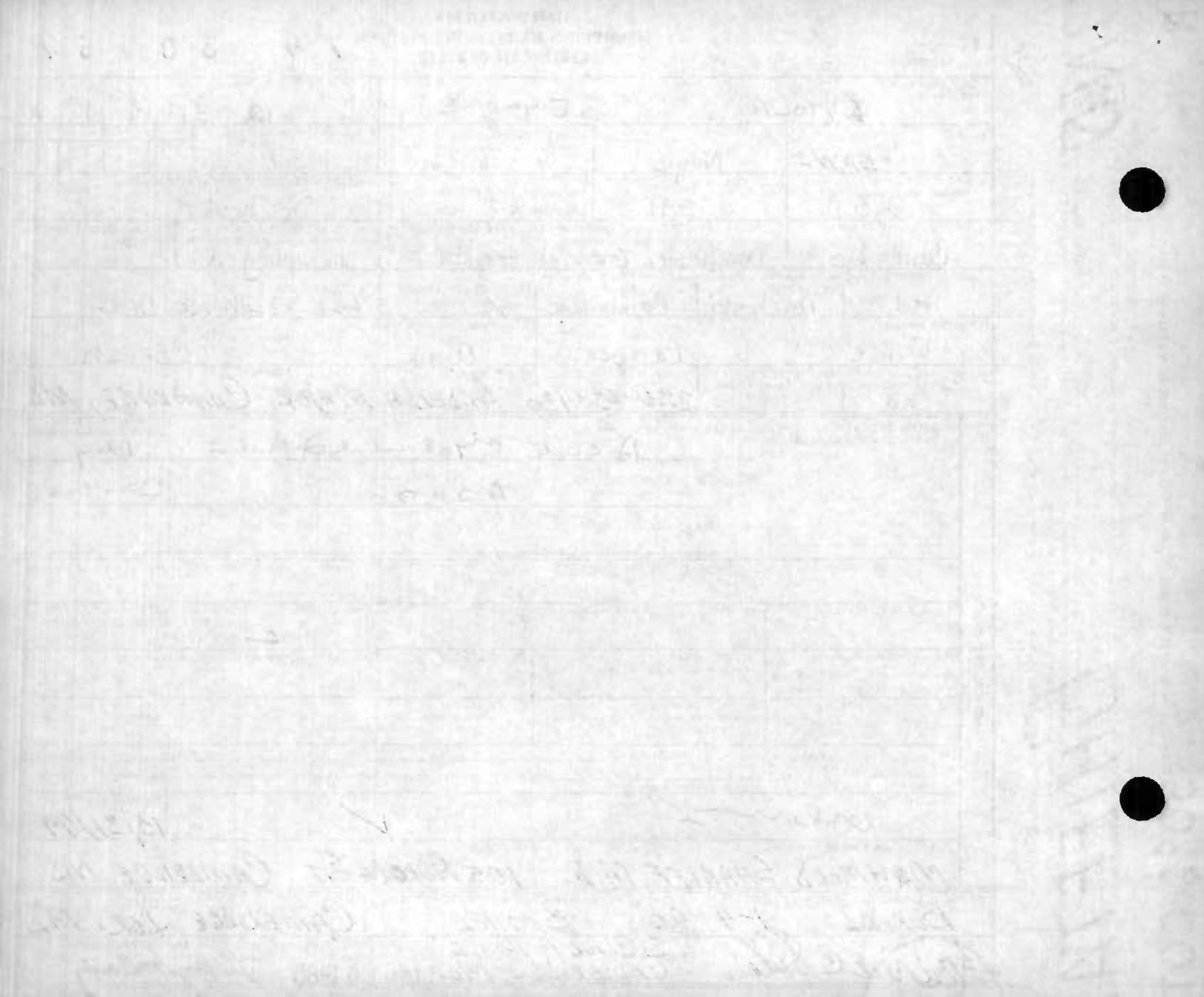


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after filing with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												7 9 3 0 9 5 7	REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
S VIOLA									SEYMORE			7 2 - 31 - 79				11 15 AM		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS				
FEMALE			Negro			MONTH 7 DAY 16 YEAR 20			59			MONTHS		DAYS				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			MD.			
U.S.A.			U.S.A.									Dorchester						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY									
Cambridge			Dorchester General Hospital						unemployed									
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS						
Md.			Dorchester			Cambridge						637 Schoolhouse Lane						
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME															
FIRST Willie MIDDLE			LAST Camer			FIRST Anna MIDDLE			LAST Cornish									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
no			220-03-1130			ADELLA MAJOR			Cambridge, Md.			1 day						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 410 - <i>A cut by a nail</i>															DUE TO, OR AS A CONSEQUENCE OF (b) <i>As h/o</i>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.															DUE TO, OR AS A CONSEQUENCE OF (c) <i>None</i>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															22c. DATE SIGNED 12/31/79			
22b. SIGNATURE <i>Leslie</i>						DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS															
MAHMUD SHARIFF, M.D.			105 Aurora St. Cambridge, Md.															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			23e. COUNTY			STATE			
Burial			1-4-80			BETHEL			CAMBRIDGE			MARYLAND						
24. FUNERAL DIRECTOR NAME			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE												
Frederick C. Klein						JAN 10 1980												



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.		
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH			MONTH			DAY		YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	May 16, 1917			12 - 7 - 79		1979		5:45 AM	
3. SEX			4 RACE	5. DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			MD.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Cambridge			Dorchester Genl. Hospital			Ret. Clerk								
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)														
13a STATE Md.	13b COUNTY Dor.	13c CITY OR TOWN Cambridge	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS			Spring Drive					
14. FATHER'S NAME FIRST Howard			MIDDLE	LAST Shorter	15. MOTHER'S MAIDEN NAME FIRST Lula			MIDDLE	LAST Shorter					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS					
NO			220-10-6729			Mrs. Murial Shorter, Cambridge, Md.								
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC FAILURE														
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hours.														
486- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Streptococcal SEPSIS														
DUE TO, OR AS A CONSEQUENCE OF (c) PNEUMONIA														
7 days. 2 weeks.														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			19c. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR: A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 21, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> DRIVING <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY AT HOME, STREET, FACTORY, OFFICE, ETC.			21f. LOCATION STREET			COUNTY			STATE		
22a. I certify that <input type="checkbox"/> (this hospital) attended the deceased from Nov 28, 1979 , to Dec 7, 1979 , that <input type="checkbox"/> (we) lost saw the deceased alive on Dec 7, 1979 , and that in <input type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above <input type="checkbox"/> (we) did <input type="checkbox"/> (did not) view the body after death.														
22b. SIGNATURE Michael A. Mosiewicz			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 12-8-79					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael A. Mosiewicz MD			22e. ADDRESS 6 Aurora St. Cambridge Ad.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Dec. 9, 1979			23c. NAME OF CEMETERY OR CREMATORIAL LOCATION Dorchester Mem. Park, Cambridge, Dor., Md.			23d. LOCATION CITY OR TOWN COUNTY			STATE		
24. FUNERAL DIRECTOR NAME Thomas Funeral Home, Cambridge, Md.			25a. DATE REC'D. BY REGISTRAR DEC 14 1979			25b. REGISTRAR'S SIGNATURE Hector J. O'Leary								

CHANGING EVIDENCE

BY THE USE OF

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.					
1 - FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR								2b. HOUR					
1. DECEASED NAME (TYPE OR PRINT)				LAST				12 13 79				4 P.M.					
HELEN FRANCES SPENCER																	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR				6. AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN			
F		W		6 25 93				86									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8				9 BALTIMORE CITY OR COUNTY OF DEATH				MD.					
Md.		USA						DOR									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					
CAMBRIDGE		EASTERN SHORE HOSP. CENTER										housewife					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS					
Md		Talbot		Easton								12 Locust St.					
14. FATHER'S NAME		FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME								LAST					
John		Willoughby		Laura								CARROLL					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.				17. INFORMANT				ADDRESS					
NO				217-01-9403				Dorothy Brewer				ESAC					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Infarction</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																	
410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost. DOUE TO, OR AS A CONSEQUENCE OF (b) <i>Generalized Atherosclerosis</i>																	
DOUE TO, OR AS A CONSEQUENCE OF (c)																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Psychosis & Cerebral Atherosclerosis</i>																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET				CITY OR TOWN		COUNTY	STATE				
22a. I certify that (I) (this hospital) attended the deceased from 10-18-72, 19, to 12-13-79, 19, that (I) (we) last saw the deceased alive on 11-13-79, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <i>E. Tanman</i>		DEGREE MD				ATTENDING PHYSICIAN		MEDICAL DIRECTOR		STAFF PHYSICIAN		22c. DATE SIGNED 12-13-79					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>E. Tanman</i>		22e. ADDRESS															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12-17-1979		23c. NAME OF CEMETERY OR CREMATORIAL Spring Hill				23d. LOCATION CITY OR TOWN Easton, Talbot, Md.		COUNTY		STATE					
24. FUNERAL DIRECTOR Newman Funeral Home		DEPOSED Easton, Maryland				25a. DATE REC'D. BY REGISTRAR DEC 17 1979		25b. REGISTRAR'S SIGNATURE <i>Henry J. Kelly</i>									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
EDWARD X THOMPSON						Dec. 27 79						
3. SEX			4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) YRS.				IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			
m			CAU	1 10 25	54							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH							
Maryland			U.S.		Dorchester							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Cambridge			Dorchester Genl. Hospital			Draftsman Electronics			Mfg Electronics			
13a. STATE Md.			13b. COUNTY Dor.	13c. CITY OR TOWN E.N. Market	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS Rural				
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
Samuel E. Thompson			Mary Yates Jones									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES			16b. SOCIAL SECURITY NO. 1950-1952			17. INFORMANT			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
			215-20-1474			Mrs. Laura J. Thompson, East New Mkt.						
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Squamous cell carcinoma of lung with metastases</i> 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>lung with metastases</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>1 year ?</i>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from Nov 15 1979 to Dec 27 1979, that (I) (we) lost saw the deceased alive on Dec 27 1979 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22c. DATE SIGNED 27 Dec 79												
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						
Lewis M. Burdette MD			4 Aurora St Cambridge Md 21613									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Dec. 30, 1979			23c. NAME OF CEMETERY OR CREMATORIAL Dorchester Mem. Park, Cambridge			23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR NAME Thomas Funeral Home, Cambridge, Md.			ADDRESS			25a. DATE REC'D. BY REGISTRAR DEC 31 1979			25b. REGISTRAR'S SIGNATURE Rickey McCreary			

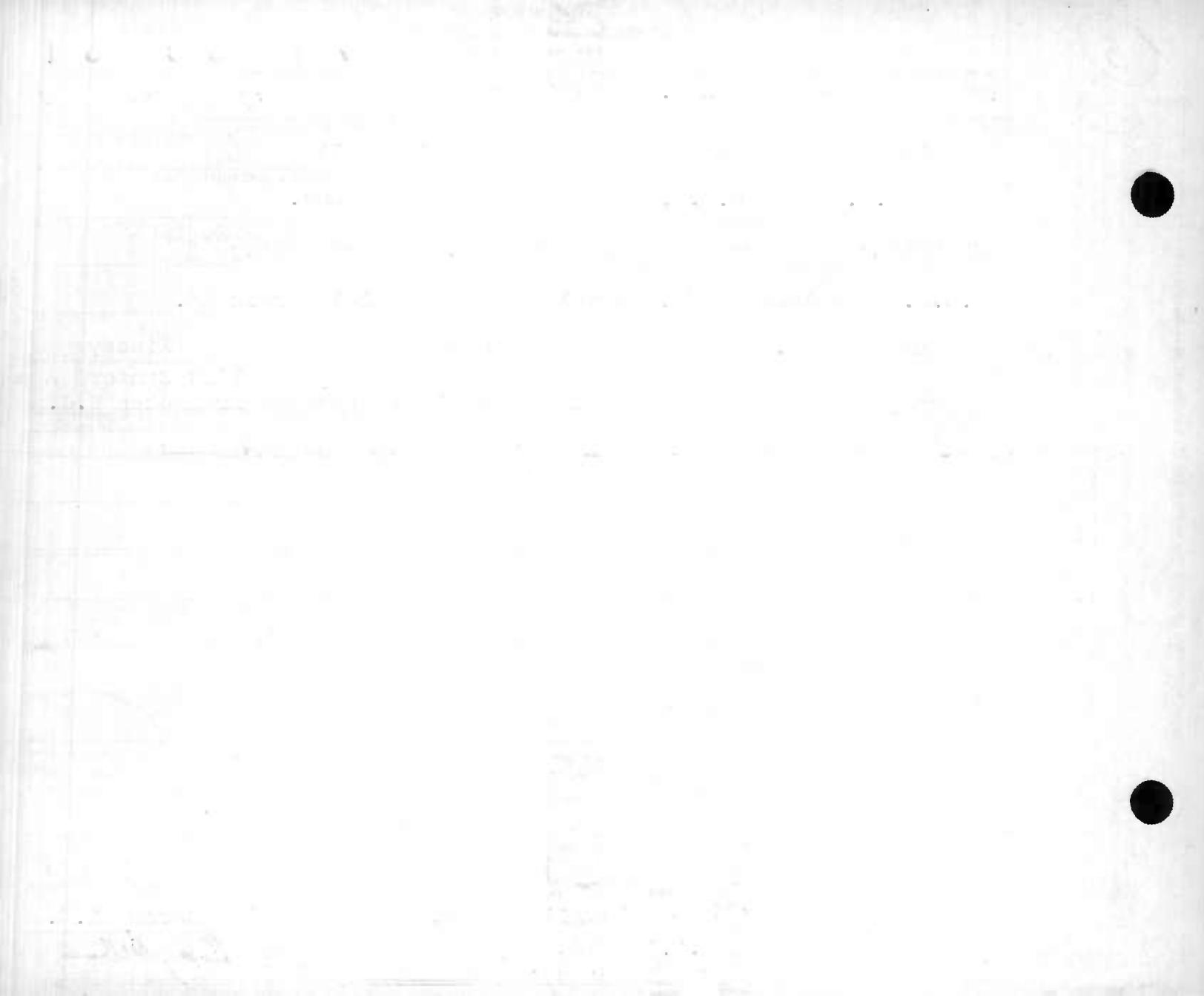
and many are lost

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.
1 - STATE REGISTRAR			79 30961									
I. DECEASED NAME (TYPE OR PRINT)		FIRST <u>Herbert</u>	MIDDLE <u>A.</u>	LAST <u>Tintle</u>	2a. DATE OF DEATH MONTH <u>Nov</u>			DAY <u>23</u>	YEAR <u>1908</u>	2b. HOUR <u>11 P.M.</u>		
3. SEX <u>male</u>		4 RACE <u>white</u>		5. DATE OF BIRTH MONTH <u>Nov</u>			DAY <u>23</u>	YEAR <u>1908</u>	6. AGE (IN YEARS LAST BIRTHDAY) YRS. <u>71</u>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>N.J.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <u>Dor.</u>			10. IF UNDER 1 YEAR MONTHS <u>0</u>		
10. CITY OR TOWN OF DEATH <u>Cambridge</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Dorchester General Hosp.</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>accounting</u>			12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE <u>Md. XXXX</u>		13b. COUNTY <u>Talbot</u>		13c. CITY OR TOWN <u>St. Michael</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <u>102 Harbor Rd.</u>				
14. FATHER'S NAME FIRST <u>Herbert</u>		MIDDLE <u>A.</u>	LAST <u>Tintle</u>	15. MOTHER'S MAIDEN NAME FIRST <u>Clara</u>			MIDDLE <u></u>	LAST <u>Kinsey</u>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>no</u>		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS <u>Hausman Funeral Home</u>			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1057 Sanford Ave</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>486-</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)		Bilateral Pneumonia								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Organic Brain Syndrome</u>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on <u>12-23-1979</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>E. Tamman</u>		22c. DEGREE <u>M.D.</u>		22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> MEDICAL STAFF <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED <u>17 Franklin St. Cambridge Md</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>burial</u>		23b. DATE <u>12/26/79</u>		23c. NAME OF CEMETERY OR CREMATORIAL <u>Bloomfield Cem.</u>			23d. LOCATION CITY OR TOWN <u>Bloomfield</u>					
24. FUNERAL DIRECTOR NAME <u>Thomas Funeral Home</u>		24b. ADDRESS P.O. Box 348 Cambridge Md. 21613		24c. DATE REC'D. BY REGISTRAR <u>DEC 31 1979</u>			24d. REGISTRAR'S SIGNATURE <u>Rickey McCreary</u>					

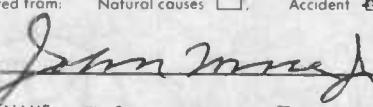


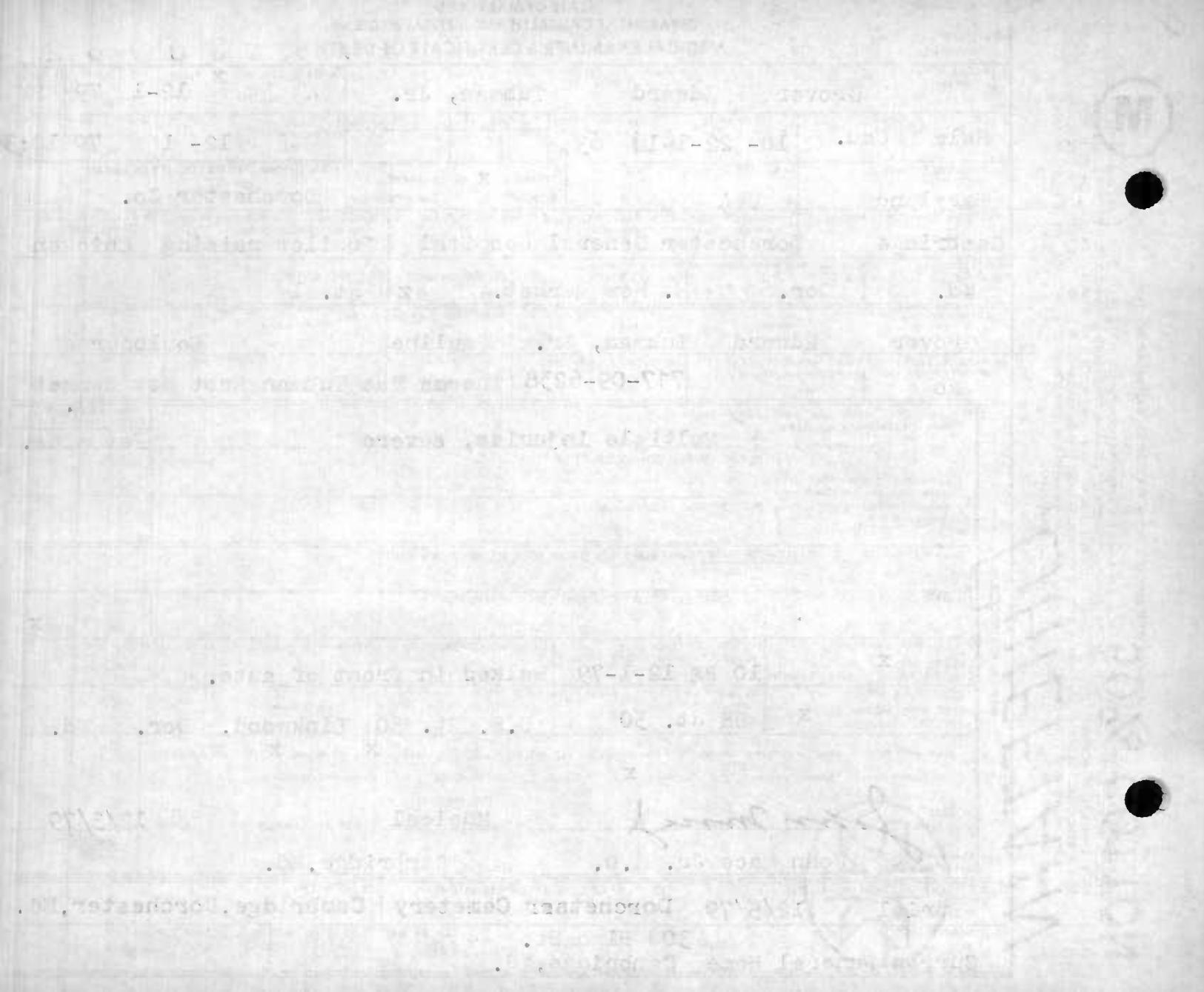


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL, IN ITEM 18, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM-3, RETAIN PAGES 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A RUFIAL TRANSIT PERMIT; PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO RUFIAL, CREAMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 30962

1 - STATE REGISTRAR			2a. DATE KNOWN OF ESTIMATE MATED													
			Grover Edward			Tubman, Jr.			MONTH 12-1 1979			YEAR PM				
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			IF UNDER 1 YR. IF UNDER 24 HRS.			2d. HOUR							
3. SEX Male			4. RACE Cau.			5. DATE OF BIRTH MONTH DAY YEAR 10-22-1916			6. AGE (IN YEARS) LAST BIRTHDAY 63 yrs.			MONTH DAY YEAR				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			2c. DATE PRONOUNCED DEAD 12-1 1979			2d. HOUR PM				
9. BALTIMORE CITY OR COUNTY OF DEATH Dorchester Co.			MD.													
10. CITY OR TOWN OF DEATH Cambridge			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Dorchester General Hospital			12e. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Broiler raising			12b. KIND OF BUSINESS OR INDUSTRY Chicken							
13a. STATE Md.			13b. COUNTY Dor.			13c. CITY OR TOWN E. New Market			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS Rt. 1				
14. FATHER'S NAME FIRST Grover			MIDDLE Edward			LAST Tubman, Sr.			15. MOTHER'S MAIDEN NAME FIRST Pauline			MIDDLE LAST Coulbourne				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 717-09-6238			17. INFORMANT Therma Mae Tubman			ADDRESS East New Market			Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Multiple injuries, severe</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Few mins.	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?										
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 10 PM 12-1-79			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Walked in front of auto.			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) US Rt. 50			21f. LOCATION STREET U.S. Rt. 50 CITY OR TOWN Linkwood, COUNTY Dor. STATE Md.										
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																
ACTUAL SIGNATURE 			TITLE (SPECIFY) M.D. Mdeical			MEDICAL EXAMINER			DATE SIGNED 12/3/79							
EXAMINER'S NAME (TYPE OR PRINT) John Mace Jr. M.D.			ADDRESS Cambridge, Md.													
23a. BURIAL-CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/5/79			23c. NAME OF CEMETERY OR CREMATORI Porchetser Cemetery			23d. LOCATION ON TOWN Cambridge, Dorchester, Md.							
24. FUNERAL DIRECTOR NAME Curran Funeral Home			ADDRESS 308 High St. Cambridge, Md.			25a. DATE REC'D. BY REGISTRAR DEC 7 1979			25b. REGISTRAR'S SIGNATURE 							
DPMAH - 17 (VR A15 ME (5)) 15M 7/77																

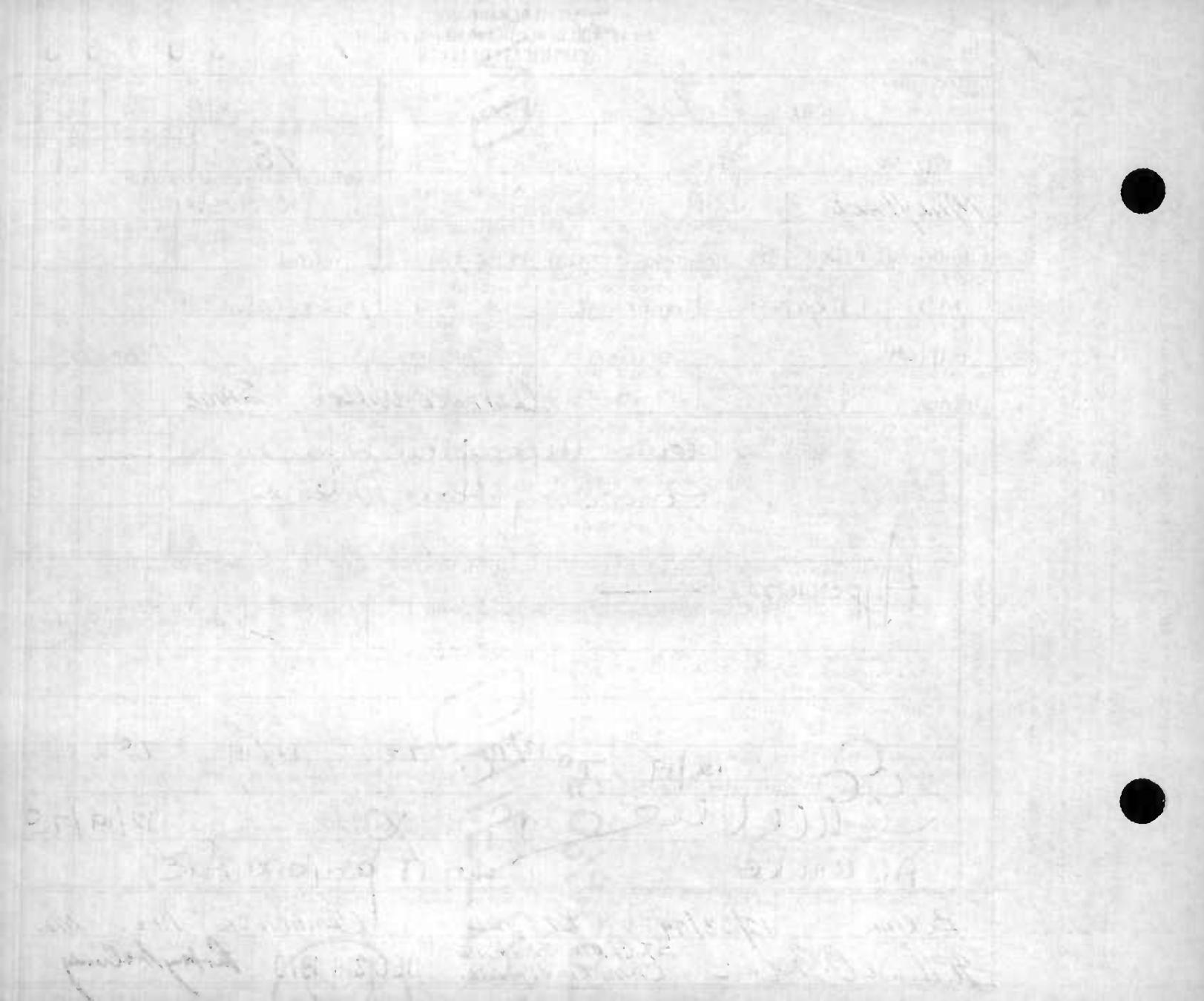


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												7 9 3 0 9 6 3	
1 - STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR									REG. NO.	
I. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2b. HOUR							
Viola B Wilson				B	Wilson	12-19-79			12:00 PM				
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)				
female			Negro			06-07-01			78 YRS.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
Maryland			USA						Dorchester				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										
Cambridge, MD			Dorchester General Hospital										
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
MD			Dorchester			Cambridge			13e. STREET ADDRESS 523 Cedar St.				
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST										
Elliot			Susan Jenkins										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
unknown			217-10-8318			Clarence Wilson			SAME				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Acute Respiratory Infection</u> 410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Coronary Heart Disease</u> (c) _____												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Hypertension</u>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that (1) This hospital attended the deceased from 12/19/79 to 12/19/79, that (1) (we) last saw the deceased above on 12/19/79, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did not view the body after death.													
22b. SIGNATURE <u>AR Wilke</u>			DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 12/19/79				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) AR Wilke			2e. ADDRESS 400 Maryland Ave.										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 12/23/79			23c. NAME OF CEMETERY OR CREMATORIAL BETHEL			23d. LOCATION CITY OR TOWN CAMBRIDGE				
24. FUNERAL DIRECTOR NAME Michael C. Blair			25a. DATE REC'D. BY REGISTRAR DEC 26 1979			25b. REGISTRAR'S SIGNATURE Linda McElroy			COUNTY Dor. MD. STATE				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 7930964	
1. DECEASED NAME (TYPE OR PRINT)				FIRST <i>Walter</i>	MIDDLE <i>WALTER E</i>	LAST <i>Wilson</i>	2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR		
3. SEX				4 RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Male				Negro		2-26 1897		82 YRS.				IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>				7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Dorchester</i>				MD.	
10. CITY OR TOWN OF DEATH <i>Cambridge</i>				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Dorchester General Hosp.</i>								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Laborer</i>	
13a. STATE <i>Md.</i>				13b. COUNTY <i>Dor.</i>		13c. CITY OR TOWN <i>Camb.</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS <i>912 Pine St. Camb., Md.</i>	
14. FATHER'S NAME <i>William</i>				FIRST <i>P.</i>	MIDDLE <i>Wilson</i>	LAST	15. MOTHER'S MAIDEN NAME <i>Pricilla J. Stanley</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <i>Yes</i>				16b. SOCIAL SECURITY NO. <i>WW 1 214-34-9077</i>		17. INFORMANT (Daughter) ADDRESS <i>Athedee B. Height Rt. 2 Camb., Md.</i>				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Days</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Heart Failure</i>				DUE TO, OR AS A CONSEQUENCE OF (b) <i>Peritonitis due to perforation</i>									
1531 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				DUE TO, OR AS A CONSEQUENCE OF (c) <i>Tumour of colon</i>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION <i>Dec 6, 1979</i>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>above</i>					20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <i>Dec 9, 1979</i>			21f. LOCATION STREET <i>Aurora St</i>			CITY OR TOWN <i>Cambridge</i>	COUNTY <i>Md.</i>	STATE <i>MD.</i>		
22a. I certify that (I) (this hospital) attended the deceased from <i>Dec 5, 1979</i> to <i>Dec 9, 1979</i> , that (I) <input type="checkbox"/> last saw the deceased alive on <i>Dec 9, 1979</i> , and that in (my) <input type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> (we did) <input type="checkbox"/> (did not) view the body after death.													
22b. SIGNATURE <i>Lewis M. Burdette MD</i>			22c. DEGREE <input type="checkbox"/> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN			22d. DATE SIGNED <i>6 Dec 79</i>							
22e. ADDRESS <i>4 Aurora St Cambridge Md 21613</i>													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>12-13-79</i>			23c. NAME OF CEMETERY OR Crematory <i>CHRIST U. M. CEM.</i>			23d. LOCATION CITY OR TOWN <i>AIRPORT XX</i>			23e. COUNTY <i>XX</i>	
24. FUNERAL DIRECTOR NAME <i>L. H. Boardley</i>			ADDRESS <i>603 Washington - Camb., Md.</i>			25a. DATE REC'D. BY REGISTRAR <i>DEC 14 1979</i>			25b. REGISTRAR'S SIGNATURE <i>L. H. Boardley</i>				

